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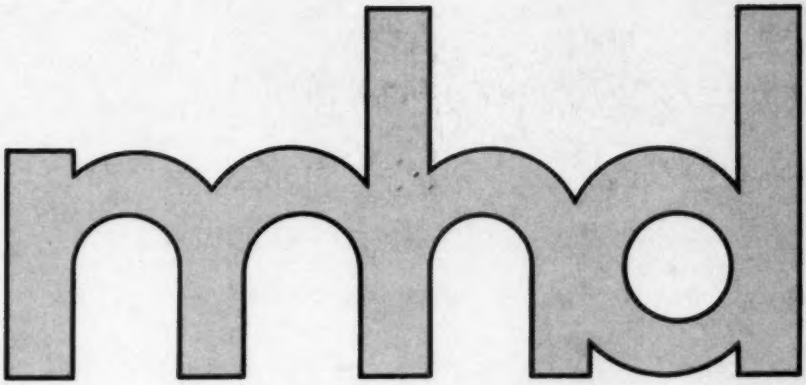

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The *Mental Health Digest* is a monthly publication designed to reflect the whole spectrum of mental health and to present a broad sampling of scientific subject matter and professional points of view. It contains condensations of material selected from the current mental health literature. The condensations are published with the approval of the authors and publishers for use in the *Mental Health Digest* only. Readers interested in particular digests are urged to consult the journal or other source in which the material first appeared or to ask the authors for reprints.

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Statement on the Community Mental Health Centers Program

National Institute of Mental Health

Since the passage of the Community Mental Health Centers Act in 1963, the National Institute of Mental Health has made funds available for 515 community mental health centers across the country. This direct support was the principal thrust of a movement to treat persons with mental and emotional illness near their homes, with as little disruption as possible in their lives and an early return to productive living.

The positive benefits of the community mental health centers concept, especially in terms of improved care for the mentally ill, has been thoroughly demonstrated and a large portion of a national system will have been established by the time that existing centers have benefited from their full 8 years of Federal support under the current law.

The future thrust of the community mental health centers concept (both in terms of a nucleus of ideas that is reforming care of the mentally ill and in terms of actual service programs emerging all over the country) is well established. At this point in time we can look forward optimistically to a shift of the primary responsibilities for initiating community mental health programs to State and local levels of government. For example, 33 States have already enacted community mental health legislation of their own, and legislation is pending in many others. Further, since the inception of this CMHC program, multiple sources of funding have been encouraged as a basic component of the program. For example, of the federally funded programs, less than a third of the total support for operation of those programs comes in the form of grants under the Community Mental Health Centers Act.

The challenge ahead for NIMH is to continue to stimulate development and strengthening of the community health center concept, and to provide sound leadership, technical assistance, and program development activities which will enable communities to establish this workable system of care for their citizens. In short, we will continue to encourage the spread of CMHC's, though no longer through direct funding, and to develop knowledge about existing or new resources that can be employed, so that our original goal of community mental health center services for every citizen of the United States can be accomplished.

* * * * *

This issue of the *Digest* contains condensations of several articles concerned with community mental health centers and other mental health services. It also contains as a Mental Health News Digest a summary of the 1974 Federal budget for mental health.

The Fires of Irrelevancy

Franklin B. Chu and Sharland Trotter

Community mental health centers were conceived by rational men sitting behind desks at a time when the word *community,* whatever else it may have meant, was innocent of political overtones. There was no grass roots involvement in planning the national program, and to the extent that National Institute of Mental Health policymakers belatedly urged community participation in individual centers, their intention was to assure local financial support and to overcome the presumed hostility of the public toward "mental illness." The social turmoil of the late sixties put fire into the word *community* and made the issue of community involvement a sensitive one for center administrators and community residents in many places.

The questions of control and accountability are among the most critical for the functioning of a community mental health center, for it is their resolution that determines how the priorities and philosophy of a center's program are established. While NIMH encourages community involvement, community boards are neither required by Federal law nor defined by Federal regulations. NIMH offers no firm guidelines as to how citizen involvement in the centers should be accomplished. The Community Mental Health Center Program Operating Handbook for 1971 states:

> Community mental health centers must involve the community in the planning, development, and operation of the program. Community involvement is required to assure that the center's program will be responsive to the mental health needs of the community.
>
> Community involvement may be formal or informal, and may include representation on policy and advisory boards . . . the participating citizens must include broad representation of all elements of the community such as professionals, lay persons, appropriate consumers. . . .

The demand for increased citizen participation has been slower to focus on community mental health centers than on more established institutions. This is partly due to the lack of visibility of the centers, and partly to the lack of public interest in them (the average citizen, after all, is not inclined to think about psychiatric facilities unless or until he has reason to need their services). As more centers come to be established in poverty areas and as a growing number of professional and lay persons who consider "mental illness" more a social than a medical problem begin to think of the centers as possible change-agents, springboards for attacking social, economic, and political injustices, the demands for participation are likely to get more vehement.

The potential for conflict is great. Many mental health professionals, while they may agree with the concept in principle, question the validity of citizens' encroaching on the planning and implementation process.

Most centers now operating have no formal mechanisms for consumer participation. Now that NIMH has begun to encourage some type of community involvement, advisory boards have been added, few of them with any fiscal control, policymaking power, or program responsibility. NIMH has offered no guidelines concerning board structure, selection procedures, or functions. The softness of the NIMH mandate has meant, again, that the concept of citizen participation is open to any number of interpretations.

In general, the degree to which citi-

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A Look at the Overlook

Bertram S. Brown

The NIMH is a Federal Agency that should be held accountable by a responsible citizenry. With this conviction, I welcomed the Nader group's interest in community mental health. As I stated when the draft report was released, I believe that it can have many beneficial effects. It can bring into public view and vigorous policy debate vital issues, concerns, and criticisms about community mental health centers, as well as about the field of psychiatry and mental health. I am pleased but not surprised that the majority of concerns voiced in the Nader review coincide with those made by staff of the National Institute of Mental Health and our Council and advisors.

Of all the questions we must continually ask ourselves, the primary question is that of relevance, and it is one posed daily in varied programs being developed and mounted locally. By relevance we mean relevance to the mental health needs of people. This is the mandate given us by Congress—to provide the mental health services relevant to people's needs—and we are responsible, to Congress and to the people, for fulfilling it.

Those of us who worked actively in the centers program from its inception were committed and idealistic. But we knew that more than money was required to reach the program goals of the Community Mental Health Center Program. Major conceptual changes in the delivery of mental health services would have to take place, major modifications in the roles of mental health professionals would be necessary, major alterations in the relationships among affiliated agencies and organizations would be required, and major shifts in public attitudes would have to be brought about.

Program reviews sometimes lose sight of the progress that has been made. Many, though not all, of the hoped-for changes in mental health care in this country have been accomplished or are on the way. The Community Mental Health Center Program has become a unique system through which a spectrum of appropriate and coordinated services are brought to residents of specific geographic areas.

For all of its accomplishments, the Federal program is still young. The first construction grant was awarded in 1965, the first staffing in 1966. Since that time, 493 community mental health centers in every State, the District of Columbia, and Puerto Rico have received grants. Only about one-fifth of the funded centers have been in operation for as much as 5 years.

When all the federally aided centers become operational, they will serve 73 million people—from inner cities to rural farmlands to affluent suburbs—with each center, or network of community services, differing and individual for the locality. By 1969 372,000 Americans had received care at community mental health centers. By 1970 the number of people receiving direct service at centers had increased to 518,000 and by 1971 the number had climbed to 659,000. Many more were reached through consultation and education programs offered by the centers to schools, courts, police and social welfare departments, and other community caregiving agencies and organizations.

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zens are involved, how they are involved, and in what they are involved is left to the discretion of the professionals. All our case studies illustrate the phenomenon. In only two centers (the South Central Community Mental Health Center in Atlanta, Ga. and the Area D Community Mental Health Center in Washington, D.C.) is community participation taken seriously, and only in one (Atlanta) were citizens involved at the outset. In *none* do community advisory boards have legal authority or responsibility.

The Metropolitan Community Mental Health Center in Minneapolis offers an example of how the professional community determines the limits of citizen involvement. In 1969 the center submitted to NIMH a proposal for developing consultation and education services, including the creation of a community advisory board. By March 1970 the Metropolitan Center claimed that a "community advisory committee" was meeting monthly to assist in planning of consultation and education services, and identified a local Indian as chairman.

A subsequent investigation by NIMH revealed that the Indian was never aware that he had been chairman. He had attended only "one or two meetings of the group, because it was clear they didn't want to do anything." Yet, the center proceeded to outline plans for "citizen involvement" in what should be a classic in how *not* to relate to the community.

A committee has been set up to develop the Community Advisory Board; the consensus of staff is to wait until the community leaders identify themselves by criticism of the program and then to invite them to be on the committee.

Two NIMH-funded evaluation studies found a similar lack of citizen involvement in other centers across the country. One of the studies points out that all but one center (participation-through-staff) reflect middle-class patterns of citizen involvement, with historical roots in charity-minded boards of housewives, businessmen, and professionals (lawyers, ministers, judges, etc.), whose function is to raise money and who do not question the domination of professional interests over consumer interests.

It seems clear that if community mental health centers are to maintain their credibility, explicit provisions must be made for citizen involvement and responsibility beyond a tokenistic advisory function. Only those who use mental health services are in a position to determine their true relevancy.

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Of particular importance, the centers have emerged as a resource for people least able to afford quality mental health care—half of all funded centers are in urban or rural poverty areas. Forty-two percent of the people added to center caseloads in 1970 were from families with incomes of less than $2,500 a year. Nearly two-thirds of the admissions had family incomes of less than $5,000 annually.

Other evidence of real accomplishment relates to the development of effective alternatives to extended hospitalization. The latest data indicate that of all persons treated at community mental health centers 13 percent were at one time confined to public mental hospitals. One-third of all new inpatients treated at centers are diagnosed as functionally psychotic, a diagnosis which might otherwise have led to lengthy custodial care. Of patients in the centers' partial hospitalization programs, which are being used increasingly as an alternative to full inpatient care, 40 percent are similarly diagnosed. Documentation is now available to show that centers are helping to reduce the inpatient rate in State and county mental hospitals of people who reside in center catchment areas.

But I don't want to imply that we have accomplished all of our goals. Certainly some centers have been more effective and better run than others. We must still reach the majority of the population who live in areas not yet served by a community mental health center. We must develop better educational and preventive programs, better treatment techniques, and better models of organization. That is part of the advantage in having a wide variety of locally developed programs, and the value of citizen participation. In terms of the overall question of "relevance," these improvements are vital.

We must operate within the broad policies and guidelines established at the national level for Federal aid and, at the same time, foster and encourage local initiative and autonomy. The balance of responsibility is a delicate one.

In evaluating citizen participation in community mental health centers, keep in mind that reliable conclusions cannot be drawn from inadequate sampling. Although the excerpt from the Nader Report gives the impression that large numbers of centers were visited, in fact only six of a total of 325 operating centers served as case examples. Community involvement is far more significant than the Report would lead one to believe. For example, two States have community boards which not only govern all community mental health centers, but also serve as grant recipients. By itself, this group encompasses 35 community mental health centers where community involvement is very much in evidence. Other States are following this lead.

Within the limits of its legislative authority, NIMH and the HEW Regional Offices are using a broad variety of means to encourage and promote increased citizen participation and involvement. Whether under the rubric of "relevancy," or community participation, or human services that people themselves have a hand in bringing about, the Community Mental Health Center Program is and must always be subject to effective and productive change.

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Mental Health Service Quality Control: An Idea Whose Time Has Come

Jack Zusman

The Rise of Interest in Quality Control

Quality control has become more important because of the influence of a number of contemporary movements. Foremost is the role of government in paying for mental health services both directly and through subsidization of local mental health agencies. American government has traditions of disclosure of the magnitude and purpose of expenditures, of competition among those interested in obtaining government funds, and of examination after the completion of expenditures to determine what the results have been. When government becomes a major factor in support of community mental health services, these traditions will be applied in the mental health area. The first question the government administrator asks is, "What are we getting for this money and could we spend it in any better manner?"

A second factor is consumerism. The consumer has come to recognize that a few organizations cheat him and many more are in a position to cheat him; and that by banding together with his fellow consumers he can become more powerful than the organizations. Associations of patients are in existence and it seems only a matter of time before they begin to exert significant influence on the providers of services. They are finding a sympathetic response in the courts.

The next factor is the increasing role of "third party payers," such as insurance companies. Previously payment for service was an individual matter between the mental health profession and the patient. Third-party payers are responding to demands to use their economic power to influence both the cost and quality of the services they pay for.

A final factor is the increased effectiveness of each practitioner to influence the outcome of his patient's illness at a time of decreasing emphasis on professional ethics and moral codes which have been a traditional part of professional education. Years ago the effectiveness of the tools available to the mental health practitioner was limited; the practitioner now has many powerful therapeutic influences available for his use. It thus has become more important to the patient that the practitioner be highly skilled as well as imbued with a sense of responsibility to do the best job in the interest of his patient.

A major expansion has occurred simultaneously in the numbers and types of individuals providing mental health services, many with little or no professional training. They have received neither the indoctrination nor the incidental training in professional ethics and responsibility which are an essential part of joining a profession. Even modern professionals spend little time studying professional history and ethics, but concentrate on technical skills. This makes it necessary for the consumer to be protected from the unscrupulous or inept practitioner beyond the weakening professional traditions.

Forces Opposing Quality Control

Quality control is resisted by professionals for a number of reasons. There is the understandable reluctance to subject oneself to examination with

possible unpleasant consequences. All of us avoid pain, and quality control will involve painful episodes for some professionals.

The traditional role of the professions is not easily compatible with external control. One essential element of a profession is its incomprehensibility (either real or assumed) to those outside of the profession. Effective quality control requires explicit standards understandable to anyone, layman or professional, and use of these standards in an impartial way so that the interests of consumers as well as professionals are protected.

Other elements of the professional tradition are in opposition. Quality control may reveal that some professionals provide better service than others which implies the possibility of competition among professionals on the basis of providing good service for patients. Yet professional tradition is that all professionals provide service of the same high quality (except those deserving censure or expulsion) and that there be no competition.

Professionalism implies an emphasis on using the correct process in treating a patient regardless of outcome; the statement that the operation was a success but the patient died is not a joke but a serious statement of good practice. To the layman or quality control expert, the statement is an example of professionals protecting one another or not understanding what the consumer's interest is.

Finally, there is the issue of loss of control over one's profession and one's professional career. Although quality control is presented in objective terms, it involves and perhaps is in essence a political process. The definition of quality determines in whose interest quality control will operate. The individual or group that defines quality is placed in a powerful position and this position is worth fighting for. In our society, the fighting goes on through the political process.

The Opportunity

The temper of our times, the increasing expense of medical and mental health care, and the complexity of service demand that quality control become an active and effective mechanism.

All of us working as mental health professionals have a unique opportunity. The standards promulgated through quality control will shape mental health services of the future. We can shape quality control. By becoming active in the development of principles and techniques and in the educating of the public, we can see to it that quality control is useful, realistic, and effective, and that the necessary political negotiating is carried on explicitly and openly. We can help to assure flexibility so necessary for the nurturance of innovation and the provision of care in unusual circumstances.

If we default in this responsibility, we will be faced by a quality control system designed by others. This may be a system which we cannot live with and which, although technically effective, will result in what has been called "the triumph of techniques over purpose."

Definition of Quality Control

Quality control or quality evaluation is measurement of the degree to which a provider of service approaches the standards set by a competent agency or authority. Quality control is a quantitative process and one which makes use of standards which can be specified and are stable from one situation to another. Quality control is objective in the sense that it

does not depend upon any particular observer, and the standards should be applicable by any observer with a minimum of instruction or experience. (In another sense, quality control is not objective.) The definition does not specify which variables will be measured. These depend upon the purpose for which the evaluation is to be done. Similarly, the definition specifies a competent agency or authority and does not say which one.

Evaluation is a necessary and useful method of upgrading the quality of services. It provides a baseline against which a facility may measure progress and provides standards as the goal for which a facility may aim.

Quality evaluation is never based upon absolute standards (since such standards do not exist). Although quality is often discussed as an abstract concept and standards as absolute, unchanging, and scientifically based, in reality standards do change and always depend upon who is determining them. Standards for clinical service are selected by a group involved in clinical practice as expert practitioners or consumer representatives or government agents. Each group has a point of view and interest in services, and the quality standards each proposes will be influenced by different circumstances. The final selection of quality standards must be negotiated among the interested groups, and standards selected will relate to the interests of the groups. Should the composition of the standard-setting body change, the standards will change.

Both the quality standards and the agency or authority which will specify and measure the quality standards are essential parts of any quality-control process. These must be selected by negotiation and agreement among the groups concerned. There is nothing scientific or objective about this part of quality control. Quality control is the application of scientific technology in the interest of a nonobjective value system. The value system is selected in some nonscientific way and then serves as the foundation upon which a scientific structure is built.

Underlying Assumptions

Let us examine some assumptions and compromises necessary to make the system function. The first is that quality is definable, can be agreed upon, and measured. The second is that the definition of quality will change but that changes take place slowly enough so that for limited periods of time quality standards can be treated as if they were fixed.

The next assumption is that the process of quality evaluation depends upon a system of measurement, a degree of objectivity, and a knowledge of clinical practices. Another is that level of quality depends upon the degree of presence of several independent factors, some directly related to clinical outcome (which professionals associate with quality) but others not related at all (e.g., patient comfort or availability of service).

It is assumed that clinical practices are influenced by scientific knowledge, available resources, accepted theory, and the place and manner in which each variable is measured. Thus, comparisons of quality among different clinical settings must take these variables into account in each setting. This situation is in distinction to "pure science" where absolute standards and definitions depend upon experimental verification and are accepted regardless of group interest. Quality control uses many scientific techniques but emphasizes and negotiates conflicting interests.

Quality Control Methods

The first technical task is to set standards. This can be done in either of two ways—the normative or the empirical.

The empirical method is probably simpler. It involves developing quality standards statistically through measurement of practices in a large number of clinical settings. Quality of service in any facility can be examined in relation to services provided in facilities of a similar type or in the same geographic area. Empirical standards are easily derivable even with present-day technology and data collection.

Normative standards are based upon the opinions of experts—on what experts in mental health care say constitutes good quality care. Of course, there must be some method of determining who is or who is not an expert.

Peer review is a variation of the normative approach in that quality of care is judged by professionals at a level of training equal to the individual whose work is being judged. The peers are not outside experts but active practitioners. Peer review seems to be a mechanism for evaluating and intervening in cases where poor quality care is suspected rather than as a mechanism for routine evaluation and upgrading of care. In such a role, its usefulness is questionable. It is also questionable whether or not individuals whose expertise is in clinical practice are capable of evaluating quality when the evaluation process calls for a separate skill.

A second technical problem is selection of the variables to be used in the determination of quality, as well as the ranges of values for these variables which will represent good and poor care. Here either the normative or empirical approaches can be used.

The final technical problem is application of the quality standards to the service to be evaluated. There are two major approaches, one making use of records kept by practitioners and facilities and the other by direct observation of the interaction between the practitioner and patient.

In record audit an evaluator reconstructs what went on during the treatment and arrives at some estimate of quality. The problem is obtaining evaluators able to carry out this reconstruction. Because of the shortage and expense of clinicians' time, this work cannot be carried out on a large scale unless it is undertaken by nonclinicians expert only in evaluation. The evaluators must be trained to appreciate the difficulties of the practitioner and to be sensitive to all the nuances of the clinical records. This is difficult in mental health services where records are skimpy and where often no attempt is made to indicate what actually transpired between clinician and patient.

Direct observation requires the placement of observers in clinical facilities. The problem is in training observers to recognize the important factors in care, as well as possible interference with the professional-patient relationship. There is a significant expense in observer time since the work depends upon the pace of the professional and patients' schedules. Determination of the quality of service depends upon observing a good sample of the service provided. A technical decision must be made how to sample service.

Our work suggests that it is difficult to estimate quality from a random selection of cases. We choose a number of common types of clinical cases and evaluate only these. Because the cases we select are common, we can be

fairly certain that they will be encountered in any facility.

Quality Evaluation on a National Scale

If quality evaluation is put into practice on a national scale there will be many problems. The first is cost. Even if cost is small in comparison to the cost of the clinical service, evaluation will add up to a significant sum of money. The decision as to what fraction of the cost of service is realistic for evaluation is one that must be decided by negotiation. Our feeling is that evaluation is important enough to be supported on a fairly large scale.

Another problem is developing standards. Although our national network of professional training agencies (primarily universities) is so interconnected that we are indeed developing national standards, the service facilities are not closely connected. It therefore becomes possible, even likely, that idiosyncratic clinical techniques have developed in discrete geographic areas. Standards on a national scale must be flexible enough to take these variations and local interests into account. On the other hand, standards must be specific enough so that pressure will be exerted on facilities falling below an acceptable national level.

Once standards are developed, there will be a significant problem to communicate them on a national scale not only to agencies but also to the group of evaluators who presumably will be scattered across the country and may never meet as a group.

The evaluation process itself must be evaluated to be sure that standards are applied uniformly and effectively, and to determine whether or not evaluation is having any effect.

The quality evaluation process must include a mechanism of appeal. A practitioner or agency given an unfavorable rating should be able to appeal and be reexamined by another evaluator. Since quality evaluation ratings may determine the survival of an agency, every safeguard against error or prejudice must be provided.

Finally, there must be some method to take into account unique situations. For example, a clinic operating in an impoverished area and just starting with minimal resources cannot be evaluated in the same way as a clinic with a long tradition of service to a well-established community. Although in theory both facilities ought to be meeting the same minimal standards, from a practical point of view they cannot do so.

Usefulness of Quality Evaluation

Given the fact that quality evaluation will be with us whether or not we want it, are there ways in which it can be helpful to mental health professionals? Indeed, there are.

A quality evaluation system will facilitate making clinical care standards explicit and uniform. This will be helpful in teaching. It will also be helpful to the administrators since they will be encouraged to state their goals and work with their staffs toward attaining specific goals.

The availability of quality ratings will make it easier for consumers to select the practitioner or facilities they wish to use. Serious consideration will have to be given to the question of whether quality ratings should become public information.

The professional will have standards he can use in his own professional development. He can design inservice training to help him meet these standards and can measure his work against the standards.

The availability of standards can be used on a national scale to upgrade

the level of services across the country, as well as to increase uniformity of services from one region to another.

Perhaps most important, the development of standards will make explicit the conflicts in interest which beset clinical services but which often are hidden and dealt with covertly. One conflict is between economy in provision of service and high quality and patient comfort. If money is no concern, a clinical facility can employ many professionals of the highest caliber and provide luxurious accommodations. Since cost always is a factor, some compromise has to be reached between acceptable cost and acceptable quality and comfort. This conflict is often not explicitly considered and it is assumed that every facility provides "the best that money can buy." By bringing this conflict into the open, it will be possible to consider what service quality a facility can afford. Patients too will know how much they are purchasing and can decide at what level of expense they want service.

A final example is the conflict between innovation and stability. Inasmuch as defined standards of care will be stable and based upon standards derived from observations in clinical facilities or questioning of experts, they will be aligned to previous practice. Obviously, improvements in service depend upon innovation. Since innovation has not been taken into account in the development of standards, the innovator may be penalized by a lowered rating. Innovation by definition involves introduction of new techniques. Some innovations will fail and, in these instances, the particular patients involved will lose out: This is the price patients pay in return for the advancement of clinical care. At present, these failures are hidden and the existence of such a process is rarely acknowledged except in lawsuits. In negotiation of quality standards, it ought to be possible to arrive at some acceptable level of innovation and acceptable case-failure level for a clinical facility. Although this may be of little consolation to the individual, it will be helpful to any individual considering treatment in a clinic to know what proportion of its treatment approaches are innovative and involve a risk of failure, as well as a risk of unexpected success.

For many years public funds have been spent on mental health services without significant attempts to measure or improve systematically the quality of services provided. The increasing involvement of government in paying for health services provides a major opportunity to correct these serious omissions.

It seems clear that the Federal government will not support any national health program without a built-in mechanism for assuring an acceptable level of service quality. All mental health professionals ought to welcome this Federal movement to require and to support the upgrading of publicly financed facilities and services.

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Problems and Prospects: Administration in Mental Health

Saul Feldman

Mental health services today are different from their predecessors. Mental health programs are spending more money, employing more people, serving more clients in more varied ways, and providing services of greater scope than ever before. Emerging are large, complex, frequently decentralized service systems with diverse funding sources, multiple levels of accountability, and complicated interorganizational relationships. The federally funded community mental health center (CMHC) is one example. Even if the CMHC is viewed as a transitional model, its features are likely to characterize the delivery of mental health services (if not all human services) for a long time. What are these features?

The New Look in Mental Health Services

Mental health services have broadened in both the range of services and in the boundaries around our traditional concerns. Every CMHC provides at least five services—outpatient, inpatient, partial hospitalization, 24-hour emergency, and consultation and education—and many provide other services. This wide range guarantees that the center will serve a broader and more varied clientele than would a single-service agency. But this multiservice approach is not confined to CMHCs alone. Mental hospitals and outpatient psychiatric clinics are diversifying their services and expanding beyond their traditional borders. The range of issues with which many mental health programs are now concerned has also broadened considerably. The debate about what is referred to as the medical versus the social model is one indication of this broadening. Mental health people are increasingly involved in concerns formerly considered outside their domain.

Size and complexity—Increased resources are necessary to make these programs work. While large budgets are not unusual for mental health facilities, the outlays of community programs are more related to staff and services than to the maintenance of large physical plants.

The staffing patterns of these modern programs reflect their increased size and diversity. The average CMHC employs 108 persons and staffs of over 150 are not uncommon, and these staffs are more ecumenical than those of the past. Many centers employ people from 16 different occupations or professional disciplines.

Mental health agencies are decentralizing their programs. This decentralization may take several forms but two are the most common: the development of "storefronts" in the community and the organization of staff into geographic teams, operating from a central base but with their own territory and clientele. Recentralization is intended to help ensure that mental health services remain accessible and responsive to the needs of the people they serve.

The contemporary mental health organization depends upon a wide variety of funding sources. Many CMHCs obtain funds from 10 or more sources, with different fiscal years, reporting requirements, and special needs. Nationwide, no single funding source provides as much as one-third of all the revenue available to CMHCs. The advent of national

health insurance may shift the balance but is not likely to decrease the diversity.

Another manifestation of complexity is sophisticated management technology. Mental health professionals now speak freely (but often unwisely) about "360–40's," "optical scanning," and "magnetic discs." The application of computers and other instruments is growing rapidly.

Organizational mosaics—Perhaps the most striking characteristic of new mental health services is the organization of programs into new configurations. Mental health agencies are cooperating and integrating their services on an unprecedented scale. A CMHC is much more a combination of services than a single facility; one center is composed of 18 different organizations.

Within this new emphasis, a major focus is on continuity of care—the easy movement of clients between services according to their needs. The barriers to such continuity are formidable. Parochial admission requirements, sanctimonious traditions, and a general organizational paranoia make continuity difficult.

These developing mental health systems are beginning to work more closely with other health and human services, with mental health recognized as a partner in a coordinated system of human services. Unfortunately, rhetoric has outrun knowledge of how to bring complex organizations together while preserving their individuality.

Changing politics and the community—As public expenditures and visibility have accelerated, mental health, health, and other services have begun to occupy the center of the political stage. Direct Federal financing and the increasing responsibility of local governments for mental health services are also changing the political scene for mental health organizations. Involvement of mental health agencies in the political process once was confined to interest in the fate of the mental health budget at the State capitol. Now, their growth and survival depend on the Congress, the County Board of Supervisors, and the interplay among all levels of government.

Finally, "consumerism" is affecting mental health services, with "citizen participation," "community control," and "relevance" becoming part of our jargon. The goal, of course, is to ensure that mental health services will be responsive to consumers rather than to providers.

Some form and degree of community involvement have become accepted in the mental health field, at least in theory. Still to come are answers to such "simple" questions as: What is a community? Who are its legitimate representatives, and how do you know? When and how do you involve the community in the mental health organization? What kinds of involvement work best where? Community involvement is a difficult process that has not been helped by pat phrases and cliches.

Implications for Administration

This complexity of administration has not been accompanied by increased administrative sophistication. In general, mental health executives have little or no training in administration. They are most frequently psychiatrists, psychiatric social workers, or psychologists who are promoted to executive positions. Lured by the prospect of increased earnings and status and by a desire to "be in a position to get things done," they accept positions for which they have had no training and little experience. They tend to

view administration as a mechanistic process separate from program substance, as something to be disposed of as quickly as possible so that time is available for the "more important and pleasurable" aspects of the job.

Trained administrators sometimes are employed, but they often have no training or expertise in mental health. Dual leadership under a mental health professional and business manager often means little or no common frame of reference to permit a unified administrative approach.

A response to these problems is hampered by several interrelated factors. There is little useful literature on administration in mental health. The field of administration in general and mental health administration in particular has been poorly defined and conceptualized. Reliable soundly based data are not readily available; instead, one is likely to find administrative slogans or mythical "principles." There are few training programs in mental health administration; those that exist are often peripheral to practical needs.

The need for a literature—The paucity of literature is both a symptom and a cause of the problem. The last major book on administration in mental health was published in 1962. In fact, published material is so sparse that even if new training programs were to develop, almost no pertinent teaching material would be available.

Because of the absence of a literature, advances and innovations in mental health administration are not likely to occur rapidly or be disseminated. New research is retarded by the absence of the stimuli provided by descriptive articles, case studies, etc. To make mental health administration visible as a career and a field of knowledge, development of a literature is essential. Without it the field will have little substance and new training programs will perpetuate the status quo.

Administration as a field of knowledge—The difficulty in defining the substance and boundaries of administration as a field of knowledge is another complicating factor. The subject matter of administration may be conceptualized as integrating four areas —generic administration, the substantive field, the organizational type, and the environment with which the organization interacts. Generic administration encompasses such areas as organizational and interorganizational behavior, planning, evaluation, budgeting, and decisionmaking. These processes are modified by the environments in which they are applied.

To be effective, the administrator must adapt the generic aspects of administration not only to the relevant field but also to the type of organization in which he is working and to the specific organizational environment. There is need for research on the nature of these adaptive processes, the differences between administration in mental health and other settings, and the implications of these differences for study and practice.

The difficulties in defining the parameters of administration are compounded by the many definitions ascribed to "administration," "program," and "policy." In my view, administration is not extricable from the amalgam of organizational decisionmaking; nor is it separable from program and policy. It is a leadership process, interwoven with achievement of program goals and central to organizational effectiveness. Administration is program, and program is administration.

This unity is often unrecognized. A result is confusion between the role of administrator and administrative specialist. The top administrator is

charged with the responsibility and accountability for the program. This responsibility includes the organization's fiscal viability, internal management, and programatic focus and direction. He should blend a knowledge of administrative processes with program substance and be sensitive to the reciprocal relationship between them.

The administrative specialist concentrates on one aspect of the management process, such as budgeting or personnel. His area of expertise tends to be circumscribed. This does not minimize the importance of the administrative specialist. In fact, the failure to recognize the impact of the management processes on program may result in the tyranny of process over purpose. The management processes, however, are only one component of the administrative function and are not synonymous with the entire administrative task.

Mutable truths—Despite advances in quantitative analysis and new technology, administrative decisions are dependent upon the values and needs of the parties to the process. Decisions are only partially related to such variables as quantifiable costs and benefits. This difficulty has fostered a search for, and a dependence upon, so-called administrative "principles." In reality, administration is situational; there are few, if any, principles in the sense of immutable truths or doctrines.

Organizational effectiveness is dependent upon many variables that must be adapted to the time, place, and circumstances. The task is not to depend upon principles, but to identify and assess those factors indigenous to a specific environment which militate against or argue for a particular approach.

Implications for training—With the scarcity of useful teaching material and knowledge about what mental health administrators do, it is difficult for training programs to prepare people for the challenges of the field.

What mental health administrators should know must be a function of what they do, what they should be doing. The content of training programs must be determined by, and relevant to, the nature of the administrative task. Information on such questions as how mental health administrators spend their time, major decisions they make, administrative structures within which they work, and the primary people and organizations with which they interact is not available. Given the tendency of academic programs to be resistant to change, it is essential that new educational programs in mental health administration be related to the "real world" in which the mental health executive functions.

Because the need for well-trained administrators in mental health exceeds their availability, there is a temptation to rush into "newer," "bigger," and "better" training programs. A more deliberate approach, while less glamorous, may be far more beneficial in the long run.

To be of value, training programs must rest on insights gained from research on the nature of the administrative task in the mental health setting and a more adequate understanding of mental health administration as a field of knowledge. Without such research and a corresponding increase in the literature, the promise of progress through new training programs may not be achieved.

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Training in Administration for Psychiatrists

Walter E. Barton

There was a time when administration in psychiatry was perceived as relevant only to superintendents of public and private mental hospitals and commissioners of State departments or mental health programs. Now more than a thousand administrative posts exist in psychiatry.

There are presently about 200 certified hospital administrators available to fill approximately 500 public and private mental hospital superintendent posts in this country.

The general hospital psychiatric section requires an able psychiatrist-clinician who has skills as an administrator. Not less than 500 sections of psychiatry are now operating in general hospitals of this nation.

There are nearly 400 community mental health centers serving as many population units. While psychiatrist-administrators direct some of these, administrators from a variety of backgrounds operate the remainder.

The divisions of government have recruited many psychiatrists into leadership positions. The search for qualified psychiatrist-administrators for government posts continues as the demand expands.

The clinician who demonstrates scholarship in the presentation of well-designed research studies and publishes his findings may be promoted to chairman of a department of psychiatry in a medical school. Qualified psychiatrists are sought for numerous unfilled vacancies.

Clinicians who relate well to their peers are sought out to serve organizations at city, State, and national levels on task forces, committees, commissions, councils, and boards of trustees.

The Requirements for a Good Administrator

There are a variety of leadership roles in the many settings noted above; the gain and/or loss from alternate arrangements under a psychiatrist-leader or an administrator from another discipline also vary. Much depends on the tasks to be done, the knowledge and skill required, and the qualities that characterize the administrator.

In my judgment, the diagnosis, evaluation, and treatment of psychiatric disorders is a primary task for the psychiatrist. The hotel function (room, board, and laundry) and personnel and business functions can be delegated. Medical responsibility for the patient cannot be delegated. The mental health system, viewed as a continuum, is best managed when a competent psychiatrist-administrator is head of a general hospital unit for psychiatric patients, is the head of the mental hospital, or directs the State department of mental health. Where other objectives of the organization, such as human services, are in ascendancy over treatment of the mentally ill, the qualified nonpsychiatrist-administrator may be the most appropriate selection.

I take the position that the qualified psychiatrist-administrator should fill the leadership roles I have cited. But some say the long preparation in medicine, psychology, social work, or nursing is expensive and irrelevant to the task. Others believe it would be more efficient to train administrators from outside the mental health professions to fill these roles.

Enough experience has accumulated to make some assumptions. Minnesota has had trained lay administrators in charge of its State mental hospitals for 10 years. The Veterans Administration has also exercised the same option. No evidence has emerged to support the view of superiority of lay administrators over well-trained mental health professional administrators.

Recent Developments in Administration in Psychiatry

Systems approach—A new style of leadership (teleocratic) is emerging, oriented to process rather than structure, mobility rather than hierarchy, and creative intervention rather than fixed rules and regulations. Competitive relations among closed systems are giving way to cooperation between open systems.

The systems approach makes it possible to conceptualize and to study the problems of relationships and of interdependence. Five basic considerations apply:

- The total system's objectives and more specifically, the measures of performance of the whole system;
- The system's environment and its fixed constraints;
- The resources of the system;
- The components of the system (subsystems), their activities, goals, and measures of performance;
- The management of the system.

The mental hospital's multiple goals can be set down as examples of the total system's objectives: the relief of symptoms of mental illness and the return of patients to the community; rehabilitation to maximize the patient's capacity for social adjustment and for living productively in the community; a facility that offers employment for individuals; a center for training of mental health professionals; research to evaluate the treatment of patients as well as the performance of employees and the success of training programs.

Relations of the hospital to the total health system may be examined. The attitude of the community toward mental illness and patients, the willingness to accept the returned patient, jobs available to patients, housing provided, and economic support required are important variables.

The resources of the system may be studied under the subdivision of facilities and equipment, manpower, money, and programs, or with regard to input, treatment (conversion), and output.

The components of the system that may be selected for study are extremely varied. Study of decentralization of control or unitization of the institution to relate to geographical areas is an example. Another might be evaluation of admission, screening, and diagnostic processes; or the demographic characteristics of the population admitted, the types of illnesses, and the degree of severity. Just as the input into the system varies and may be important to the output, so does variation occur in the treatment process, the resources available, the rehabilitation program. The output of the system is the individual returned to the community, trained worker, and educated professional, as well as others.

Decisionmaking—As organizations have become more complex in pursuit of multiple and changing goals, so has the complexity of the environment in which the leader must function.

The two principal management systems are: planning, programing, and budgeting; and cost analysis or cost effectiveness.

Planning examines trends, estab-

lishes priorities, and forecasts required resources in manpower, facilities, and finances needed to accomplish objectives. What will be done, how, and by whom constitute the program. The program, expressed in fiscal terms, becomes the budget. Each program element has its cost and an appropriation under which it will be financed.

To determine cost effectiveness, the questions may be asked: Do the services reach the population with a need? Are the services effective in getting the job done? Who receives the service and who does not receive the service?

To determine the cost benefit, we may ask: Do the services benefit the population served? Do the services do any good?

If we visualize the administrator as the hub of a wheel on which external pressures are exerted, the spokes of the decisionmaking wheel represent those groups and individuals with whom he must deal in planning, program, and budget (PPB), and in making alliances, bargains, and compromises (ABC).

For the mental hospital administrator, the spokes of the decisionmaking wheel include:

- The superior governmental agency or individual to whom the administrator is directly accountable;
- The related governmental agencies—courts, legislature or agencies for health, education, and welfare;
- The professions—chiefly the medical society, psychiatric district branch, societies for the mental health professions;
- The public—its voice is increasingly heard as it demands partnership in policymaking, planning, and institutional control;
- The patient—his involvement in decisions that affect his welfare is encouraged;
- The staff—employees' motivation and cooperation must be ensured for successful program development;
- Special inteerst groups may be supportive and friendly; however, some groups may be antimental health and opposed to its goals;
- Special purpose groups—include the communication media, newspapers, television, and radio.

The administrator should know his environment and have the capacity to build alliances. This requires not only administrative skills and ability to communicate, but endurance sufficient to meet hostility and job stress, energy and drive, patience and tolerance, and also ability to pick up cues and deduce relationships, the capacity to tolerate change, and the determination to achieve the organization's goals.

Is it Possible to Train Administrators?

Certain basic traits seem essential to the successful administrator. He must be able to see the woods beyond the trees, to conceptualize a problem, set goals and develop a method for reaching them. It helps if he can make decisions without rumination and anxiety. The capacity to communicate, to make others share enthusiasm for an identified purpose, boundless energy and persistence in working toward goals are features of many successful administrators. It is possible to teach an approach to problem-solving. There is also an identifiable body of knowledge in administration that can be transmitted.

Since 1951, the American Psychiatric Association has had a Committee on Certification in Administrative Psychiatry that has given examinations to qualify psychiatrist-administrators. More than 500 psychiatrists have been so certified. Some of the topics covered include:

- *Administration and Organizational*

Theory—Structure; dynamics of policy formation; decisionmaking; planning, etc.

- *Administrative Practice*—Delivery systems, crisis intervention; prevention; consultation, etc.
- *Medical Care Administration*—Decentralization; programs of therapy; utilization review; accreditation; records, etc.
- *Budget and Finance*—Types; planning; control; revenue sources, audits, etc.
- *Personnel Administration*—Policy; health and safety; fringe benefits; labor relations; grievance procedures.
- *Law and Psychiatry*—Civil rights; right to treatment; commitment; responsibility; confidentiality; guardianship, etc.

The knowledge and information required in these areas can well be covered in didactic courses. However, more is needed. Classroom experiences cannot substitute for an ongoing, supervised experience with a preceptor who is an expert in administration.

Training in Administration

If the primary objective of an organization is to provide quality care and treatment to the individual with a psychiatric disorder, the qualified psychiatrist is able to make the necessary judgments as to what must be done and how it will be done, and to evaluate the success of the judgments made. He brings to his task qualities that serve him well as an administrator: the understanding of motivation, the ability to listen with sensitivity to what is said or not revealed and to observe the effects of the communication, the awareness of impact of change on behavior, the patience to time interventions to the adaptive capacity of those with whom he deals, a flexibility in transactions with a wide variety of personality types.

He also brings handicaps. He may have selected psychiatry because of his protest against authority and his wish to be his own boss. He may have learned relationships with an individual person and work best directly with the patient rather than with others. He may have no management skills and little opportunity to test out his leadership skills.

Without going into a detailed presentation of the process of administration, I will review briefly some aspects important in any administrative process.

Investigation determines what work is to be done, why it needs to be done, how it is to be done, and what is needed most to do the job.

Planning involves program, personnel, facilities and budget, for these are the basic building blocks that look at the program and the resources at hand to carry it out.

Forecasting studies the trends and evaluates the relevance in relation to other developments of the program under study.

Organizing is the capacity to act through others, directing the responsibility of an individual to see it through.

Coordination is the bringing together of the systems toward a common purpose and objective at hand by removal of the barriers and resistances.

Control seeks to ensure that money is wisely spent and work efficiently supervised in a productive manner with quality control.

Inspections follow the progress and compare the results achieved with standards.

Evaluation determines whether the program objectives were accomplished.

All of this requires special abilities in decisionmaking and in relationship to the various systems or representatives of organizations and governing bodies whose cooperation, and sometimes approval, is required.

How Important Is It to Train in Administration?

For too long we have taken good researchers or clinicians and promoted them to administrative jobs with the expectation that they would learn on the job. Service pressures are often so severe and staff shortages so extreme that most have been content with a bit of orientation, some overlap with a retiring administrator "to see how he did it" and on-the-job learning as they go along.

Organizations have become too complex for use of this method; it is important to prepare administrators for the tasks they perform. A time for learning and a mode for continuing education in administration are essential if we are to have efficient management that controls costs, provides maximum cost benefits, and evaluates its performance.

Motivation and Sanctions

The motivation to learn administration in psychiatry has been dampened by the scarcity of educational opportunities. In order to encourage further development of training opportunities, two additional steps are necessary:

- The requirement of a certificate in administrative psychiatry to hold a top management post;
- The requirement of evidence of compliance in continuing education as a requisite for membership on hospital staffs and in the American Psychiatric Association.

The Time Is Now

It is impossible to teach all the subject matter a physician must know. Postgraduate instruction is imperative to attain the needed depth of knowledge. It is also imperative through continuing education and the establishment of patterns of learning to continue growth throughout a professional lifetime.

The APA has published a guide to continuing education, *Prospects and Proposals: Lifetime Learning for Psychiatrists*. The district branches of the Association are striving to implement that program and to provide a variety of learning experiences. One component of any program should be administration in psychiatry.

Coincident with the development of learning opportunities and with the imposition of standards, it is hoped that the American Board of Psychiatry and Neurology will reopen its study of the feasibility of establishing a subspecialty board examination in administrative psychiatry.

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Critical Issues in Psychiatry: A Call for Reassessment of Our Nation's Mental Health Care

Perry C. Talkington

In 1953 the president of the American Psychiatric Association called the nation's attention to the need for greater public support for the care and treatment of the mentally ill, for training, research, and prevention. Subsequently leaders within the APA evolved the idea of a commission to survey the nation's resources and make recommendations for combating mental illness. In 1955 the Joint Commission on Mental Illness and Health was authorized and funded by Congress. The commission published its report, *Action for Mental Health*, in 1961.

Nearly 12 years have elapsed since the publication of *Action for Mental Health*. It is time for an evaluation of its results, a reassessment of mental health care in the United States. I propose a second Joint Commission on Mental Illness and Health.

The specific functions and goals of this second commission cannot be delineated without thorough study. We must examine those efforts of the first commission that did not bear fruit and that must be revived, redirected, or added to. I would like to address myself to some of the changes that I see affecting the second commission's work.

The Right to Adequate Health Care

Although there is no opposition to adequate health care for all, the question of how it is to be financed, by whom and for whom, has remained unresolved. By 1905 the American Medical Association had become interested in European proposals for health care. In 1908 the labor unions were urging creation of workmen's compensation and health insurance. From 1910 to 1920 the AMA and the Federal government supported one another in developing proposals for health insurance. They then parted ways on whether it should be financed at the State or Federal level, with the AMA sanctioning health insurance only for the poor.

For the first time since 1920, the providers of medical care are not opposing the general idea of national health care. The AMA has been presenting its Medicredit bill to Congress since 1969. The American Hospital Association has been preparing a national health insurance proposal since 1969, but its Ameriplan has not yet come before Congress. The Department of Health, Education, and Welfare began in 1969 to explore solutions to the problem of long-term methods of financing medical care; this has followed many previous studies by HEW of the general area of health-care financing.

Labor has continued its interest. The AFL-CIO has not altered its position in favor of national health insurance. Today's Kennedy-Griffiths bill is an outgrowth of efforts by the United Auto Workers union. It was one of a dozen national health proposals introduced to Congress during 1971, when 30 more were on the drawing boards. Government, labor, and medicine now are each polishing versions for consideration by the 93rd Congress. For the first time, we may witness collective bargaining for health benefits on a national scale.

That brings us to one of psychiatry's major concerns. Throughout our Federal government's history, the mentally

ill either have been ignored or have been denied their right to treatment by specialists or in specialized hospitals. So, if a national health program is adopted, it probably will treat the psychiatric patient as nonexistent, as uninsurable, or as a second-class citizen.

And what of the psychiatric coverage available under the private health plans? While coverage is more widespread than it was 10 years ago, it is usually more restrictive than for other illnesses. The insurers claim that to include mental illness in the same way as other illnesses would bankrupt the health insurance system. But within the past few months the APA has published *Health Insurance and Psychiatric Care: Utilization and Cost,* providing evidence that this would not occur. To fail to include mental disorders among the illnesses that will be covered in any overall health insurance plan would be unjust, shortsighted, and result in wasteful and harmful provision of care for supposedly physical illness when an ailment is primarily of a mental or emotional nature.

In order to fulfill our covenant to provide quality medical care to the people of this nation, the American Psychiatric Association has initiated an attempt to identify all the lacunae in our present system. Our insurance study represents a major step in that direction, along with our efforts to convince Congress that the psychiatric patient should have an equitable share in whatever national health insurance plan is adopted.

We are concerned about the spiraling costs of medical care. No bill before Congress makes constructive suggestions for controlling them. In the last 11 years, the costs of hospitalization have increased 131 percent. We can no longer engage in partisan discussions of whether psychiatric services should be provided in the public or the private sector. It is time to devise a uniquely American plan for the total public-private mix of psychiatric services. A number of States have found that they can purchase quality services from the private sector of psychiatry more economically than they can provide them directly. It is in the interests of economy that similar arrangements be incorporated into overall plans for delivering effective, accessible mental health care.

Manpower Shortages

We must seek ways to correct maldistribution of physicians and medical services. We must seek the aid of every resource in an attempt to redirect the flow of medical manpower and services into the ghetto and rural areas. The problem of outpatient medical care in those areas is real. An estimated 24 million Americans, due to lack of knowledge, transportation, or financing, are said to have little or no access to ambulatory outpatient care.

There is a shortage of physicians in America, but the medical profession is responding. Medical schools have expanded their enrollments, and some 25 new schools have been built since 1960. The total net increase in physicians is significant. However, in our ghettos there is only one doctor for every 10,000 citizens. One solution has been to train indigenous paramedical workers, but it has only been partially satisfactory. Many of them leave their neighborhoods to live and work elsewhere. For those who remain, we do not have evidence of how effective their services are, or how acceptable to those they treat. Nevertheless, some social scientists continue to propose the creation of physician surrogates.

We wonder who will train and su-

pervise these new workers. Who will teach them dedication and mercy? Physicians believe that a medical education reinforces personal concern and devotion to duty. Can this abbreviated training in medical techniques also call forth and enhance those qualities?

Distribution of Physicians

Even if there were enough physicians to meet per-capita needs, the pattern of distribution among specialties is unbalanced. There is an oversupply of physicians in some specialties and shortages in others. The number of psychiatrists has been increasing faster than the population growth, and appointments with private psychiatrists are available in most cities. However, there are shortages in the State hospitals and other programs. Also, with the increasing participation of psychiatrists in community consultation and education activities, the amount of time available for clinical practice is decreasing.

Estimates of the shortage of psychiatrists vary between 20,000 and 75,000. That disparity in figures indicates a need to define what and where the shortage actually is.

We must continue to see that enough psychiatrists are being trained to meet identified needs. For the last several years, 10 to 11 percent of medical students have gone into psychiatry. If Federal funding for training is discontinued, in 3 years' time the production of psychiatric residents will decrease 36 percent. The APA, our district branches, and our allied organizations must work to find alternatives to Federal funding for psychiatric training.

Delivery of Services

How the issues of health-care financing and manpower are resolved will determine the course of our number one concern, the delivery of effective and accessible mental health services. A great many changes have occurred during the past decade.

Mental hospitals have created many new kinds of community-based services, independently or in connection with community mental health or neighborhood health centers. The hospitals are closely involved with other agencies serving the public—schools, churches, courts, neighborhood organizations, and general health and welfare services.

While it is essential to develop as many resources as possible to maintain patients in the community, it is vital that inpatient hospital services continue to improve. There are many patients who need the intensive care and protective, structured environment that 24-hour care can provide. For most, it will be but an episode in their treatment; for a small segment of our admissions, it will have to be a more prolonged course. For all of them, it is important that we offer the best care and treatment that our knowledge affords.

There is increasing utilization of all types of inpatient facilities, with both public and private hospitals showing a significantly higher turnover of patients since 1960. As a result, in most places there are beds available. Composite figures for short- and long-term psychiatric hospitals drawn from the 1971 statistics published by the American Hospital Association show an occupancy rate of 86.5 for Federal hospitals, 84.7 for State hospitals, 84.1 for hospitals operated by local governments, and 77.8 for private hospitals. The average rate in psychiatric units of general hospitals is around 78 percent. We can see that there is no overall shortage of psychiatric beds. The task for the future will not be to add

beds, but to replace outmoded or inconveniently located facilities.

Some State hospitals have closed, most have reduced their number of beds, and others are using their vacant wards to care for the mentally retarded. With greater use of other hospital and community facilities, there is danger that many State hospitals will be left with a chronic population. It is mandatory that they be given the resources and the support to maintain viable programs.

The private sector, which includes a majority of the psychiatric units of general hospitals as well as the private psychiatric hospitals, has been assuming an ever-increasing share of the inpatient-admission load, particularly of first admissions.

The higher turnover rate among the voluntary general hospitals is partly due to their customary practices of providing brief emergency care and of not retaining long-term patients. However, many, if not most, patients do not need to be transferred to another facility, but can be maintained as outpatients by their private psychiatrist or another physician, or perhaps a psychiatric clinic or day hospital.

Community Mental Health Centers

All these issues must be reviewed in relation to the community mental health movement. The community mental health center is an attempt to answer the question of how to provide services to the outpatient or inpatient who has not found existing services adequate or accessible. It may be a partial solution to the problem of delivering medical services in our inner cities.

These centers must be able to deal with individuals who are troubled, who are sick, who straddle the line between normal and well. They must be staffed in such a way that no mental or physical illness is overlooked. They must interact with their community's physicians, social workers, psychologists, nurses, school personnel, clergy, police, judges, and consumer representatives, to be a source of information for all, so that when help is needed, proper referrals can be made.

The American Psychiatric Association feels responsible for the community mental health movement. Throughout history, it has urged both State governments and the private sector of medicine to provide decent care for the mentally ill. At the Federal level, its leaders supported the creation of the National Mental Health Act, which resulted in the establishment of the National Institute of Mental Health.

NIMH and APA have worked together to upgrade the quality of facilities, manpower, and research required to improve the care of the mentally ill and to prevent mental illness. Both organizations have invested resources to ensure the success of the community mental health movement. Our investment is so great that we cannot let this movement fail.

NIMH has been carrying on an intensive attempt to evaluate the community mental health centers. I feel that its efforts would be augmented by an examination of our total mental health system. The creation of a second Joint Commission on Mental Illness and Health would provide the high-level evaluation required to see where we have come and where we must go.

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Other People's Children: The Day Care Experience in America

Sheila M. Rothman

Very few recent proposals in social policy have received such enthusiastic and unqualified endorsement as the idea of day-care centers. To a wide variety of proponents, the establishment of centers for the care of preschool children seems like a good idea whose time has come. Such a reform, they contend, will beneficiently reorder the existing relationships between sexes, generations, and social classes and will allow women to join the labor force. But the argument for day-care centers goes much further than this. According to day-care proponents the centers will resolve the conflict between the child's welfare and the mother's welfare, for they will offer advantages that neither the nuclear middle-class family nor the economically deprived lower-class family can match.

Still another proclaimed purpose of day-care centers is to bind the social classes to each other; through the centers lower-class and middle-class children, blacks and whites and chicanos, and their parents will all come into regular contact with each other.

Given this definition of potentialities, day-care supporters call the centers the "right of every preschool child in America." Still, before investing large sums of money in day-care centers, we had better know what we are building.

The Beginnings of Day Care in America

The first American day-care center —or day nursery, as it was then called —opened in New York in 1854, the work of a group of the city's wealthy ladies. They were going to assist impoverished, unfortunate women through the trauma of giving birth and simultaneously obtain wet nurses for their infants. The ingenious plan called for a combination foundling home, lying-in center, day-care center, and employment bureau. The mother came to the center in the last months of her confinement, had her baby there, then nursed not only her own infant but one other one as well—either a foundling or the infant of an employed wet nurse. After 3 months, if her milk was adequate and her behavior proper, she faced a choice of accepting a position as wet nurse or taking her infant and leaving the center. If she chose to be a wet nurse, she left her own infant in the day-care center and went to work in the homes of "the better sort." Thus the poor had a place to have their babies and a means of employment. The wealthy had wet nurses, the gratifications of benevolence, and the chance to teach the downtrodden the right rules for living.

The characteristics of this first day-care center reappeared time and again: Throughout the 19th century, and well into the 20th, it was the elites that organized and administered day-care centers. Their definition of proper behavior set the tone for the enterprise. The purpose of the centers was not merely to allow poor women to earn income but to bring them and their families under the "right influences." The centers tried to encourage female employment in the "socially desirable" occupations—that is, in domestic and not factory work.

In the closing decades of the 19th

century, as foreign-born immigrants crowded into America's urban slums, the day-care movement spread from one city to another. With the zeal and confidence of missionaries to the natives, the benevolent-minded leased brownstones in the midst of ghettos and eagerly set to work.

Their biggest prize, of course, was the child. They had him in their control at least during the daylight hours, and they were not going to waste the opportunity. He was to be transformed into a strong, intelligent, respectable child who would become a law-abiding and hard-working American citizen, and he was also to serve as guide and teacher to his own family. His affection, cleanliness, and good manners were to inspire his parents to emulation.

Moreover, the day nurseries devoted considerable energy directly to the uplift of the mother. They made efforts to find her domestic work, certain that the moral refinements of a proper household would do much more for a girl's welfare than the factory. Some day-care centers organized classes for women to learn to do laundry, housework, cooking, and sewing. Some centers also included school-age children in their programs, so that the nursery took care of the youngest, the kindergarten the next oldest, and afternoon clubs and playground groups the oldest. So from breakfast till night, the day-care centers tried with energy and good will to pass on their special brand of values and skills.

The Settlement Houses

Reformers in the Progressive period first attempted to "professionalize" day care, to make the centers' programs part of a social welfare policy. The centers moved into new settlement houses where young dedicated college women now supervised the children and designed a systematic program of education, medical care, and mental hygiene to bring coherence to an odd assortment of programs.

The Progressives' agenda for the centers was to make them innovative nursery schools. Children from 3 to 6 years old were to learn under the Montessori method; the centers at the same time would train kindergarten teachers in the newest pedagogical techniques. Moreover, day care would provide access to medical facilities, children would receive regular physical and dental checkups, and mental health advice. A social worker administered social casework assistance where necessary. The settlement house also tried to integrate older children into its program through clubs and to service mothers through instruction in English, crafts, and homemaking. Centers grew very popular, and in 1916—the high point for the movement—there were 695 licensed day-care centers operating. But in short order conditions in the day-care centers deteriorated; they grew less popular, and the number of licensed centers declined to 600 in 1925. Like so many other social welfare institutions, they enjoyed a brief spurt of seeming excellence and then suffered a prolonged lapse into mediocrity, or worse.

One cause for this rapid decline was the competition that came from another reform, the widow-pension movement. Social workers and settlement house leaders invested their energies into the framing and eventual passage of widow pension legislation. Thus the Progressives' priority was to keep the mother at home with her children, so that day care had a quality of second choice about it from the start.

As a result of this judgment and the

passage of liberal legislation, the day-care clientele quickly became stigmatized. They were the unworthy poor; otherwise they would be at home with their children, living on a pension which was now available. The centers soon had more vacancies than children, and within a decade they moved from second choice to place of last resort.

By the 1920's day-care center operations bore little resemblance to the plans of their founders. Illegitimate children, along with those whose mothers had no choice but to work in factories, now made up the bulk of the centers' children. Rapid turnover of both children and staff became typical, and there was little left of a coherent program. Investigations of day-care conditions revealed that over half the centers did not meet basic standards of cleanliness. In most centers the children's play was undirected, the equipment was poor, education was totally absent, and general supervision was inadequate.

The New Social Workers

Yet despite all these disappointments, the idea of the day-care center as a viable and important means for social improvement did not die out. Between 1925 and 1930, the newly professionalized social workers took hold of it, eager to turn the centers into places that would bring casework techniques to bear on the "pathologies" of the poor.

The new model for the day-care centers was the child guidance clinic. Hence, the social workers of the 1920's focused on the product of the "unstable home." From their perspective, personal as well as social problems had their origins in psychological maladjustment—if only the poor could be cured of their emotional disturbances, then they and the system would benefit. At the heart of this effort was to be the day-care center; in it children and parents together would be taught the right rules for living.

In the day-care operation the social workers were to be the central figures—administering elaborate admissions proeedures, intensifying the relationship between the families and the nursery, channeling information between the nursery teacher and the family, and doing casework therapy with the family to improve "adjustment" and "functioning." In essence, the center social worker would promote family and community stability, bringing a new order to the lives of the poor.

For all the novelty of the terminology, this program was little more than an updated restatement of the most traditional viewpoint on the poor and on day care. To be sure, the social workers were now eager to work with the "hard core," previously thought to be incorrigible. But their approach and their goals remained traditional. United Charities made day care an essential item on its list of causes worthy of support. So, by the close of the 1920's, centers were once again beginning to grow in number and in reformist appeal.

The Great Depression intervened, however, bankrupting most private charities and making it impossible for them to support existing centers, let alone expand them. Moreover, by 1933 the bulk of professional social workers had been pressed into government service to staff the relief and works agencies. Finally, in WPA projects and in private industry preference went to men, on the assumption that they had to support families. A nation suffering so keenly from unemployment did not want to employ wives or single women. So with clients,

supporters, and staff occupied elsewhere, day-care centers limped through the 1930's.

The one exception to this general condition during the Depression was the founding, under the auspices of the WPA, of some day nurseries. Their purpose was simply to provide jobs to teachers and hot meals to poor children. Turnover in both clients and staff was high, facilities were inadequate, and the entire effort was really a minor venture in relief-giving.

The War and Its Aftermath

The next great national emergency, World War II, opened occupations which had been traditionally closed to women, and women in unprecedented numbers filled the labor force. Accordingly, in 1942 (under the Lanham Act) the Federal government appropriated funds for the care of preschool children. On a 50–50 basis, it matched State funds for organizing or expanding day-care facilities. The growth of centers that followed this act was incredible, and under the press of this emergency effort the centers themselves were of makeshift quality. Set up wherever a few rooms could be had, they fed the children, kept them from harm, and allowed their mothers to work.

But these were temporary efforts—a 1942 day-care conference organized by the Children's Bureau decided that the centers should *not* be constructed right next to the defense plants. For then they might be *too* convenient—the centers might outlive the emergency and encourage women to stay in factory work after peace had come. As soon as the War was over, the Federal government stopped funding the centers. To most observers this meant that stable and middle-class mothers could get back to doing what they should be doing—raising their own children.

In the decade and a half that followed World War II, a new group of women, ignoring traditional injunctions, began to enter the labor force. To an unprecedented degree, lower-middle-class and middle-class women began to work, and the number of working mothers increased. In 1948, only 20 percent of the women in the labor force had children under 18; by 1958, the number swelled to 30 percent. Yet these two changes had little or no effect on the day-care movement. Of the 5.1 million children under 12 whose mothers worked full time, only 2 percent received group care; for those children under 6 years of age, the figure was a mere 4 percent. What day-care centers there were were grossly underused; they operated at most at two-thirds capacity.

In other words, the first major influx of women into white-collar jobs took place *without* the assistance of day-care centers—and without any public demand for such assistance. In fact, the service agencies and the public at large continued to define day-care centers as appropriate only for "problem" children, those from "marginal" homes, in a psychological or economic sense. Well into the 1960's, hardly any observers valued group care over the home; they defined the centers as appropriate only in those cases where the mother might otherwise abandon or give up the child.

The Day Care Revival

And so the matter rested until the late 1960's, when the day-care idea was revived, largely by educated women from the middle and upper classes. They perceived day care as a very useful method for facilitating the

advancement of their own careers without sacrificing their children's welfare. But however worthy their ambitions, one must treat their solutions with a great deal of caution and skepticism with regard to public policy. The decision of middle-class or upper-class mothers to send or not to send her child to a day-care center is ultimately a voluntary one. They have discretion and power; they act as free agents, choosing their side and taking the consequences.

But the rhetoric of these day-care-center advocates has much more serious repercussions for the poor, particularly the welfare mother. The women's liberation rhetoric justifying day care has coincided with pressures to curtail the numbers of mothers on relief, to get the "shirkers" off the rolls, to restrict Aid to Dependent Children, to make welfare mothers enter the job market. For those persuaded of the propriety of these measures, legitimized day care provides the socially acceptable mechanism for getting welfare recipients back to work, and at the same time for transferring the care of their children to "better" hands. But until now day-care centers, for all their inadequacies, were typically part of a voluntary and private charity effort; the poor did not have to use them. Today, however, we are entering a new stage, wherein the government, under the threat of withholding relief, can compel the poor to put their children in the centers.

The project that most unequivocally demonstrates the coercive potential in linking day care with welfare is the federally sponsored Work Incentive Program (WIN). Established in 1967 by Congressional legislation, WIN was ostensibly designed to provide welfare recipients with the training and skills necessary to get them jobs in the open market. When WIN served women—that is, mothers receiving ADC—the day-care center became a basic structure. Because of the new-found legitimacy of group care, legislators could, for the first time, compel needy mothers with children under 6 to enter the job market via the WIN program. Their rationale, of course, rested on the superiority of the new day-care centers; once there was no need to be worried about the child's welfare, there was every reason to insist that the mother earn her keep. However, WIN has proven to be a very costly program, unable to get ADC mothers into the job market, and unable to provide first-rate child care.

Promise and Reality

The WIN experience is typical of day-care center ventures: They do not fulfill their promises. In January 1972, New York State initiated a day-care center program based on the federally approved sliding scale of payments; the scale was to enable all classes to take advantage of day-care facilities, paying according to their needs. In effect, however, it subsidized center care for the poor and placed public facilities beyond the means of almost everyone else.

The New York experience is not unusual. A study of 500 centers in all regions reported that most are essentially segregated, serving either whites or blacks exclusively, and the failure of licensed centers to achieve or maintain adequate standards of care is even more disheartening. In fact, the reality of public day care as it now operates is dreadful, and there is no prospect that conditions will improve substantially in the future.

Part of the failure of centers to offer good care reflects the inability of municipal or State governments to de-

vise mechanisms for enforcing standards. To date, officials have relied exclusively on licensing, a woefully inadequate procedure in this instance. Nor have the centers solved the problems of staffing. The rapid turnover in and the absence of credentials among personnel reflect more than just a low salary scale; they also point to weaknesses in the founders' conceptions as to who would be running the institutions. Proponents insist that early childhood education experts will perform the task. But early childhood education is not a well-established field, with incontrovertible and tested principles that only need to be systematically learned and applied. The field is still too uncharted to serve as the basis of a day-care system.

Giving the Poor a Choice

There is a long and disheartening tradition in this country of reform rhetoric legitimating new institutions which, in the course of one generation, decline into custodial places, or worse. Benevolence has flowed from the top down, from experts in moral uplift or psychology or pedagogy to the poor and their children.

The day-care center movement belongs to this tradition. As always, proponents are not at a loss for persuasive arguments. But as always, the fundamental issues are economic and political. If we are going to spend billions of dollars for day-care centers, and if most of this money goes to middle-class professionals, is that really the best way of helping poor families? And do we want to give government the right to coerce mothers into placing their children in day-care centers so they can go to work?

Given the potentiality for abuse in day-care centers, it would seem better to trust the poor rather than to trust the administrators or those who claim to speak for the poor. Rather than encourage the Federal government to make appropriations directly or exclusively to day-care centers, it would be more equitable and less risky to use the funds to establish a generous family assistance program. In this way, parents could exercise their own discretion. They could select this day-care center or that one, or none at all. They could decide to leave their children under the supervision of someone else, or to forego job training in order to take care of them themselves. Critics are acutely sensitive to the dangers of abuse here—for the mother to remain idle or to spend her money foolishly. But they pass ever so lightly over the dangers of alternatives, such as founding institutions for child care that lack adequate supervision and personnel.

It remains true that getting Federal money allotted to the poor is no easy matter, and many day-care supporters urge the funding of centers as a strategy for loosening purse strings in Washington on behalf of the poor. But the prospect of coercion in a day-care program more than outweighs its advantages as a fundraising ploy. The autonomy of decisionmaking must be an essential part of any child-care arrangement. If autonomy is not respected, in 10 years we will be advocating, not day care as the right of every American child, but the organization of a Committee for the Rights of Children in Day-Care Centers.

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Psychiatric Day-Care: The New Chronic Population?

K. W. Cross, Christine Hassall, and D. Gath

Although day care has become a major form of provision for psychiatric patients in the community, few systematic studies of this mode of care have been carried out. Here we report a study of seven day-care facilities in Birmingham, England.

Psychiatric day services in Birmingham serve a catchment area of 1,250,000 persons. Day care is divided between four large psychiatric hospitals (A, B, C, and D) in descending order of size and three small hospitals (E, F, and G) also in descending order. The type of provision varies considerably between the different hospitals.

A 1-week census was taken of all day patients attending these facilities. Information was collected in two stages: During the census week a precoded form was completed; items were abstracted from hospital case notes and included demographic data, diagnosis, duration of present illness, previous day-patient and other psychiatric care. During the next 12 months, information concerning attendance patterns and mode of discharge was compiled from hospital registers and by interviewing medical and nursing staff.

Demographic and Clinical Characteristics

During the census week, 647 patients attended the facilities, with 583 at the four large hospitals and of these 342 at hospital A.

In all hospitals together, women outnumbered men by three to two. In the large hospitals, many female patients were elderly, while the men were young or middle-aged. In the small hospitals, all patients were younger, three-quarters of them being under 45 years of age.

In all hospitals the proportion of single, separated, divorced, or widowed patients was above expectation. In the large hospitals the main diagnostic categories were schizophrenia and affective disorders, neuroses, and personality disorders. Patients in the large hospitals carried a greater morbidity, as measured by previous inpatient admissions and length of previous care as day-, in-, or outpatients.

Attendance Rates

Mean weekly attendance rates were calculated for each of the three trimesters: the trimester ending at the end of the census week; the trimester ending 3 months later; the last trimester of the 12-month followup period.

The patients were subdivided according to whether they were in day care before the census week for less than 3 months (short stay), 3–12 months (medium stay), 12 months and over (long stay). For each subgroup and in each trimester, attendance rates were higher at hospital A than at the other large hospitals. In the small hospitals, attendance rates were high in all three trimesters, though only two patients were still attending in the last trimester.

For all patients, the mode of discharge was examined in relation to type of hospital, length of day care before the census week, patient's age, and diagnosis.

Discharge

Type of hospital—Discharge patterns differed widely between large and small hospitals.

In the large hospitals, the majority of patients (64 percent) were still in day care at the end of the 12-month followup period, while 15 percent had returned to the care of a general practitioner, 10 percent had become psychiatric inpatients, and 4 percent psychiatric outpatients.

In the small hospitals, only 3 percent were still in day care at the end of the year; 36 percent had returned to the care of the family doctor, 6 percent (four patients) had been admitted to psychiatric inpatient care, while the largest group (42 percent) had become psychiatric outpatients.

Of the total population of 640 patients for whom the mode of discharge was known, 58 percent were still in day care at the end of the followup year, and 75 percent were still receiving hospital psychiatric care of some kind.

Length of day care before census week—The percentage of patients attending at the end of the followup period was consistently related to the duration of day care before the census week: The proportions ranged from 32 percent for those who had attended for less than 6 months to 83 percent for those who had stayed for 2 years or more.

Of those who had attended for less than 6 months, 15 percent and 16 percent were discharged to psychiatric inpatient and outpatient care respectively, and one-quarter were discharged to their general practitioners.

Patient's age—Of the small number of patients of both sexes under the age of 25 years, one-third were still attending at the end of the followup year. The proportion still attending increased with increasing age: 43 percent aged 25–44, 66 percent aged 45–64, and 67 percent aged 65 and over. In the two older age groups there were differences between the sexes: 71 percent of men aged 46–64 were still attending as against 62 percent of women, while in the over 65 age group, the proportions were reversed, 52 percent and 70 percent respectively.

Diagnosis—A large proportion of the 232 schizophrenic patients were in psychiatric care at the end of the followup year: 71 percent were still attending as day patients and a further 9 percent had become inpatients. The corresponding proportions were 52 percent and 6 percent of patients with affective disorders, and 55 percent and 19 percent of those with senile psychosis. The highest proportion of patients returning to the care of the family doctor was among those with neuroses (61 percent).

Day care may be defined as "a transitional or intermediary stage between home and hospital." The usual concept of day care is of a rapid turnover of patients on a scale of weeks or months, rather than years, but in Birmingham this short-term concept applies to a mere one-tenth of the day-hospital population, virtually those patients who attend the small hospitals. This has important implications for the planning of future psychiatric services. While it is desirable to visualize a form of short-term day care, which may be sited in general hospitals, it is essential not to neglect the problem of the large group of patients requiring long-term support.

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Patient Training Prior to Entering Psychotherapy

S. R. Sauber

The purpose of this paper is to outline a simple approach to precare which attempts to fill the gap in outpatient work between initial patient contact and subsequent treatment. The approach is "pretherapy training."

Three basic approaches have been used: role induction training in which a group of patients take part in a pretreatment session; vicarious pretherapy training based on imitation learning and modeling procedures; and therapeutic reading in which the patient is presented with materials to study with the purpose of "orienting" him as to what to expect and how to get the most out of his therapeutic experience.

Pretherapy training can be directed at two levels: the specific and the more general. Many cases can be categorized according to problem areas such as "family" or "vocational"; patients then can be assigned to a pretherapy training condition which offers structuring in relation to specific needs. However, cases often cannot be easily classified or there is a low frequency of cases in certain areas of maladjustments. Patients then can be assigned to the more general structuring procedures in which the pretherapy training is relatively content-free.

A general approach to pretherapy training covers an exposition of psychotherapy, a description and explanation of the behavior expected of the patient and therapist, preparation for typical therapeutic phenomena, and induction of improvement expectations within several months. Therapy is explained as a learning process, and expectations of ups and downs are discussed along with the meaning of unconscious, importance of self-disclosure and the expression of feelings toward the therapist, role of daydreams and fantasies, role of the therapist, and importance of keeping appointments.

The vicarious pretherapy training session focuses on the patient-therapist dialog by showing what takes place in a "live" therapy session. A videotape may begin with an orienting and preparatory phase to the treatment process, but emphasis may be placed on demonstrating the application of the therapist's techniques to the patient's problems.

For marital problems the pretherapy training is based upon the therapist's definition of the nature, limits, and goals of marital therapy. The content areas of the different training approaches are directed toward the "neurotic interaction in the marriage" (the mirages of marriage and the dysfunctional communication patterns between the partners), and toward the therapeutic process.

An example is presented here to show the nature of the content areas covered during the pretherapy training. In terms of emphasis or time allotment, the first and last categories often receive the most attention, and the middle two content areas receive a lesser extent of concentration.

First, the psychotherapeutic model is explained to the patients. The discussion of the model is divided into the following stages: realization of problem and need for help; establishment of the relationship; expressing feelings, and clarifying problems; exploring feelings and personal resources; awareness and expectancies of desirable directions for change; work-

ing through feelings and inducing change through reinforcement and interpretation; developing insightful awareness and planning action; externalizing, terminating, and evaluating the relationship.

Second, marriage counseling is explained as a form of psychotherapy in which there is a special concern with the ways in which marital partners interact with each other. The reasons for unhappy marriages are divided into two main causes: real incompatibility between the wife and husband; a neurotic disturbance which makes them think and act in such a manner that there "appear" to be fundamental incompatibilities.

One example of the irrational beliefs and mirages of marriage that is presented is:

It is essential for your husband to love and respect you, no matter how stupidly, boringly, or annoyingly you behave; and if he does not, then you do not have real love in your marriage and things are calamitous.

Explanation: This irrational idea means that you firmly believe that, no matter how you behave, your husband, just because he is your husband, should love you; that if he doesn't respect you, life is a catastrophe; and that his main role as a husband is to help, aid, and succor you rather than to be an individual in his own right.

Rational Counter-Belief: It is enjoyable (but not necessary) to be loved and approved by your husband a good portion of the time, but it becomes catastrophic "not" to be, "only" if you tell yourself it is. If you avoid thinking: "Isn't this horrible that my husband does not love or approve of me?", and think: "I wonder how I can function so that I will more approve of myself," it is likely that your husband will have more esteem for you; but even if he continues to be uncooperative, "you" are now thinking and functioning more realistically and will be happier.

Third, there is no "not" communicating. Everything a person does in relation to another communicates some kind of message. Faulty communication is often the most crucial determinant for marital dysfunction and pathological behaviors. Clear communication is a skill which can be learned.

Fourth, a dialog of an actual case is presented.

On the basis of a telephone or walk-in intake interview by a clinic staff member, patients may be assigned to one of the pretherapy training sessions with a brief explanation of the purpose of a "single 45-minute orientation meeting." Individuals who show evidence of alcoholism, brain damage, mental deficiency, or who are under the age of 16, as well as those who have had previous psychotherapy or who appear to have unusual theoretical knowledge of the therapeutic process should be excluded. Following the pretherapy session, an appointment may be scheduled with one of the therapists on the staff, and formal psychotherapy may begin.

Once pretherapy training has been established as a routine activity, it becomes considerably easier to identify and assign patients to their respective problem areas and construct a number of more specific content structuring procedures for each of the training approaches. Although pretherapy training has face validity, further evaluation is needed to define more precisely its influence and interacting effects.

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Training Parents As Behavior Therapists: A Review

Barbara P. Berkowitz and Anthony M. Graziano

Behavior modification as an alternative to traditional forms of child therapy has been demonstrated with virtually all child diagnostic categories. Demonstrations reported through about 1967 were mainly limited to descriptive case studies dealing with clear, single-problem behaviors. Therapy was limited to clinic and hospital settings, had little followup, lacked important controls, and reported little data.

These criticisms of early work, while not detracting from the impressive case demonstrations, do suggest refinements needed if behavior therapy is to mature: greater specificity and control of variables; validation of current methods and generation of new methods; greater focus on modifying complex, multiple-problem behavior; large-scale delivery of behavior modification services; and greater focus on the clients' natural environment.

Training parents as behavior therapists for their own children attempts to overcome some major limitations of traditional child psychotherapy, i.e., traditional therapy is seen as an essentially "artificial" situation, occupying only a small portion of the child's life and possibly only having incidental relation to it. The therapist in an office might never observe parent-child interaction in its natural environment or the behavior which brings the child to the clinician. The therapist's data are usually limited to his 1-hour, weekly cross-sectional slice of the total reality of his young client's life, and to the retrospective reports of parents not trained in behavioral observation. Further, some parents receive little practical guidance from the therapist and find no ebbing of their feelings of helplessness and rage.

Despite recent attempts to overcome such limitations, the main direction of therapy has traditionally deemphasized the child's natural environment which is composed primarily of his family. Yet a child's maladaptive behavior has been acquired in his natural environment and can best be changed by modifying that environment. Moreover, the maintenance of newly-developed adaptive behavior also depends upon successful modification in the natural environment. If the natural environment is not modified, new adaptive behavior developed in a clinic may be extinguished at home and maladaptive behavior which has been extinquished or in some way decreased in a clinic may be reinstated at home. The technology of behavior modification has provided greater access to the natural environments of children than ever before, and the parents can thus become active behavioral cotherapists, the therapist's partners in the therapeutic endeavors.

The behavior therapist shares his knowledge and techniques in order to teach others to bring about and maintain improved child behavior. This constitutes a significant departure from the traditional therapist-client-role relationship, and by providing nonprofessionals with techniques and skills to deal with or prevent future problems, behavior therapy has moved the focus of treatment several steps closer to a prevention model of mental health service. The sharing of professional responsibility will undoubtedly raise many questions, and more attention should be directed to a careful ex-

amination of the implications for professional ethics and for eventual preventive mental health programs.

Parent Training in Respondent-Based Techniques

In an experiment employing an electronic respondent conditioning device with functionally enuretic children, parent training was minimal, consisting only of recordkeeping of bedwetting and instructions in the daily use of the apparatus to condition children to awaken on full-bladder cues. Both frequency and severity of bedwetting were more effectively and quickly reduced with the conditioning device than with psychotherapy and a no-treatment control group.

Despite several design limitations, the study is of interest for several reasons: These devices can be readily purchased and easily used at home by parents; supervision can be provided by such personnel as visiting nurses, thus making services more available; and remission rates were significantly better in children treated by their parents with the inexpensive alarm device than in children treated by professionals employing psychotherapy.

Conditioning treatment of enuresis still is a fertile research area with many unanswered questions and many implications for more effective mental health services. But from the available evidence it seems clear that the direct conditioning treatment of enuresis has become an effective procedure yielding excellent clinical results. It may have become so technically routinized so as to no longer require professional involvement except in a minority of particularly resistant cases, and may be entering a phase of "common" knowledge, perhaps eventually taught in home economics courses and described in popular childrearing books.

Combinations of operant and respondent techniques have been used to desensitize fears in two children, and as a treatment for tics. In another case, an 8-year-old boy for whom nightmares led to frequent sleepwalking was conditioned by his mother to respond by "waking up" to the nightmares, which was incompatible with sleepwalking. The nightmare presumably became a conditioned stimulus for awakening, losing its stimulus control of sleepwalking.

These cases have used the respondent model as a basis for organizing clinical approaches; respondent principles have been used to bring about the decrement of maladaptive behavior and to establish new behavior. Because of the lack of controls, however, it is not possible to specify the contributions of conditioning to the reported improvements of behavior which, in each case, might have been accounted for by a variety of other variables. Well-controlled experimentation is needed to determine specific respondent methods and their effectiveness in controlling a variety of common maladaptive children's behavior. Nevertheless, improvements were observed and should not be dismissed. What can be concluded is that: respondent paradigms are useful models around which clinical strategies can be created and maintained; and parents can be trained to apply respondent-based techniques to behavior. Such training appears to be a relatively uncomplicated task which may yield high clinical returns.

Training Parents in Operant Techniques

Studies involving training parents in operant techniques cover a wide range of presenting problems and intervention approaches. Most parent-therapists are taught the use of differential reinforcement, often paired with a

timeout (TO) contingency as a mild punishment, in simple acquisition and decrement, as well as in more systematic shaping programs. In extreme cases, less common techniques have been employed (e.g. electric shock). In the present review, the studies have been arranged along dimensions of: the nature and complexity of parental involvement; the level of knowledge and sophistication in learning theory principles acquired by the parents; and the level of rigor and sophistication of the methodology employed. Programs reported in the literature vary from elementary contingency management for simple presenting complaints to complex behavior modification programs for severe multiple behavior problems. Within these papers, parental involvement varies from carrying out strictly defined instructions with little or no systematic learning required, to participation as a cotherapist in observation, behavioral analysis, program planning, and carrying out the treatment plan. The following studies are grouped according to their position along the above dimensions, and will be presented starting with the least sophisticated and moving to the most complex programs. For each paper, we will also briefly describe the behavior treated in order to indicate the variety of clinical problems approached in this manner.

Minimal parent involvement—Relatively uncomplicated presenting complaints were handled through simple positive reinforcement and extinction. Although the presenting problems were apparently satisfactorily dealt with, the parents were not required to master high levels of behavior theory or methodology. Little data were collected, no control conditions or reliability checks were maintained, and training was uncomplicated, consisting mainly of instructions to parents, with modeling (parent observing the therapist) used in one account.

Simple extinction of a 21-month-old boy's severe bedtime crying was accomplished by putting him to bed pleasantly, leaving the room, and remaining away. Cessation of bedtime crying was achieved in 19 trials.

A 10-year-old selectively mute girl, who spoke only to her parents and a few close friends, had undergone 1 year of traditional psychotherapy which achieved some improvement in "emotional problems" but no change in her speech. Arrangements were made for her to attend a special class and live with one of the teachers, returning home on weekends. Instructed by the therapists, the teacher employed: shaping procedures to bring about increasingly frequent and audible speech; a desensitization process for speaking in the presence of the teacher's husband; and an allowance contingent on asking him for it first through silent mouthing, then increasingly louder vocalizing. Her parents were informed of the procedures and urged to employ them on weekends. A 1-year followup showed normal speech and no behavior problems.

A 9½-year-old incontinent boy was diagnosed as psychotic, brain-damaged, and retarded. An operant program to shape an appropriate toilet behavior utilized reinforcers consisting of attention, verbal praise, and his choice of several play activities. The mother applied the same procedure at home during the day and a modified version at night. Eleven weeks of school and home training established bowel control and diurnal bladder control; furthermore, there appeared to be positive secondary effects, such as improved parent-child interaction. Followups showed maintenance of the improvements.

Complex behavior problems and greater parental involvement—In this group of studies the parents applied portions of the programs at home. Parent training ranged from being given specific instructions, being taught specific techniques such as relaxation training and limited token systems, to some modeling through observing therapist-child interaction.

The problem behavior was more complex: an 8-year-old anxious, underassertive boy who had frequent severe nightmares and sleepwalking; a 9½-year-old boy with frequent massive tics of the face and limbs and explosive scatological verbal expletives; a 14-year-old girl who suffered from excessive depression, crying spells, and anorexia nervosa; a 4-year-old extremely aggressive, hyperactive, manipulative boy; and a hospitalized 4-year-old autistic boy with many severe surplus and deficit behaviors.

Programs were aimed at both decrement and acquisition. In three completely operant programs, parents were taught contingency management techniques such as timeout (TO) procedures and social approval, whereas the other two cases involved parents in both operant and respondent techniques including the use of token systems, social approval, negative practice, and relaxation training.

All five of these studies, with varying degrees of methodological sophistication and parental involvement, presented programs for complex behavior problems, applied by professionals, in professional settings, with parental involvement as secondary, partial, or later aspects of treatment. The parents carried out portions of programs, but did not gather data, plan or evaluate programs, or learn general behavioral concepts beyond those immediately necessary to carry out their therapist-assigned tasks.

Considerable parental responsibility for home treatment programs—These papers deal with reasonably complex behavior problems and develop greater parental involvement than those previously discussed, but their treatment methods have not been validated, and they are more like exploratory case studies than empirical validations of procedures.

The parents of a 6-year-old schizophrenic boy were trained to modify his surplus behavior of loud yelling, fearful cringing, clinging to his mother, eating and smearing nose mucus, spinning in tight circles, and hand-flapping. Behavioral deficits included little appropriate social behavior, virtually no speech, and no eye contact. In the clinic, after reducing surplus behavior through manipulating immediate social reward, the therapists began a speech training program. The mother observed these sessions, was coached in the consistent use of appropriate contingency management, and, with the father, helped to carry out similar procedures at home. Both surplus and deficit behavior diminished.

Another approach used the "bug in the ear," a small, one-way communication device to train parents in a clinic setting. The "bug" is worn by the parent while interacting with the child in a playroom with the therapist observing through a one-way mirror. The therapist can speak directly to the parent through the "bug," providing immediate instructional feedback to quickly and effectively shape more desirable parental behavior. Such instructions as which behaviors to ignore, which to reinforce, and how to use verbal and social reinforcers can be quickly given and applied. Effective results were obtained, and the technique seems to have provided a good deal of immediate, specific, instruction to parents, who had consid-

erable responsibility and active involvement in carrying out the treatment programs.

Parents were helped to eliminate fire-setting behavior in their 7-year-old boy through a treatment program involving suppressing fire-setting by making it a discriminative situation for effective punishment, i.e., Robert was clearly told that the next fire would result in destruction of his new and highly prized baseball glove; a system of monetary and social rewards was designed to strengthen the behavior of bringing matches to the parents; and nonstriking behavior in the presence of matches was strengthened, i.e., in a game with his father, Robert was allowed to strike a whole packet of matches if he wanted but was given a penny for each match he did not strike. Social rewards were always paired with the tangible reinforcers, and the father, on his own, faded out the monetary reinforcers, replacing them with praise and approval. The child was never seen by the therapist, who met with the parents in a couples group in which marital and family problems were discussed. Although there was little formal education in learning theory principles, the parents helped design the program, were primarily responsible for its application, and learned enough about principles of reinforcement to make adjustments in the program almost entirely on their own.

High parental involvement and methodological rigor—These studies have successfully combined methodological rigor, parental responsibility, and treatment of serious problems within the natural environment. Parental training was essentially limited to the problems at hand and not aimed at teaching general principles and competency for their own future independent application. The aim was primarily therapeutic and not preventive, and, although parents had considerable responsibility for carrying out programs at home, they had little to do with planning them.

The mother of a 5-year-old girl used differential reinforcement to eliminate severe self-scratching behavior. The mother gradually thinned out token rewards, eventually relying solely on social reinforcement. The program successfully eliminated scratching in 6 weeks, and the gains were maintained in a 4-month followup. An important secondary effect was the improvement in parent-child interaction.

A 3-year-old boy, diagnosed as autistic and having a history of grand mal seizures, showed the following surplus behaviors: crying and screaming up to 14 hours a day, highly aggressive behavior, and biting himself and others. He was generally deficient in age-appropriate social skills. Six 1-hour sessions were held in the home during which the parents were trained to observe and record behavior, and to use differential reinforcement, which included parental attention and a TO contingency. A 6-month followup indicated that all gains had been maintained.

Parents were trained at home in applying differential reinforcement which consisted of ignoring maladaptive behavior, TO, and social rewards paired with food or special toys. They successfully modified the severe screaming, fighting, negativism, teasing, and "bossing" of their 4-year-old son. The parents did not have responsibility for observing and recording data, and their training was apparently limited to specific techniques of dealing with the present problems.

Complex clinical and home programs—Complex therapy programs, combining direct professional involve-

ment in clinical settings with fairly extensive parent-operated home programs, have been used for treating serious multiple-problem behaviors. Each of these papers, compared with those discussed above, utilized higher levels of controlled methodology, reliability and validity checks, as well as a greater degree of parent training. Parents seemed to have been more carefully and completely trained, and the clinicians more consistently employed baseline measures, multiple observers, and reversal-to-baseline procedures. There appears to be a greater complexity of behavior problems, more complete parent training, and more confidence in the effectiveness of the procedures used. However, the parents were not involved in many aspects of the programs—particularly in observation, program planning, and evaluation—and they did not receive adequate training to enable them to formulate and carry out programs independently.

Two cases involved autistic children: Clinic treatment was used first, the mothers observed and learned techniques, and home programs were phased in later. Both children exhibited both surpluses and deficits, and the programs were designed to affect changes in both directions. Careful baseline, treatment and posttreatment measures, and close supervision in the home were used. The parents participated in observation and home treatment, and their level of training seemed to have enabled them to maintain the progress and to some degree operate more independently in the future. The greatest difference in approach in the two reports involves their use of punishment. One used a variety of positive rewards and TO procedures. The other also used shouting, shaking the child, spanking, and an electric cattle prod. The latter child showed dangerous and severely disturbing surplus such as hyperactivity, howling, moaning, climbing to high places (with many subsequent injuries), rocking, and markedly aggressive behavior with younger siblings. The therapist concluded that the surplus behavior had been incompatible with, and had therefore prevented the development of, adaptive behavior, and its subsequent reduction through use of punishment had as a major side effect an increase in adaptive behavior.

In cases of five boys whose severe "oppositional" behavior was modified, the basic approach involved shifting the mother's attention to the child's cooperative behavior, and training her to use a variety of social and other positive rewards, combined with TO procedures, to decrease oppositional and increase cooperative behavior. Trained observers obtained baseline and posttreatment measures, both in the home and clinic, and analyzed mother-child interactions. All training was carried out in the clinic. In some cases, a light signal system was used to cue the mother to respond to the child and, later, as a reinforcing feedback after the mother made a "good" response.

A report of similar programing involved a 4-year-old boy whose undesirable behavior included tantrums, aggressiveness, destruction of his clothing, hitting himself, no toilet training, poor speech, and general uncooperativeness. The mother was trained to observe specific behaviors and to appropriately and immediately use: verbal instructions to the child; TO; and attention, praise, and affectionate physical contact as rewards. Baseline reinstatement was used to evaluate the effectiveness of the contingency changes introduced. All observation,

training, and evaluation was carried out in the home.

Nineteen mother-child pairs, the largest operant group yet discussed, were trained in a 6-week, two-stage program of 15 half-hour laboratory sessions. Modeling and direct training in mother-child sessions, the "bug in the ear," and videotaping were used to train mothers in differential reinforcement, i.e., to become more "socially rewarding" mothers. The level of parental involvement was high, as the mothers were trained to observe and analyze (i.e. to look for antecedents and consequents) their own as well as their child's behavior. However, none of the training was carried out in the home —it was assumed that proper generalization to the home would occur. While these papers appear valuable in focusing on generalized interactions and in clearly describing the details of training methods, the effectiveness of those methods for improved child behavior are not known because of incomplete reporting.

Two cases of the "brat syndrome" were reported. One was an 8-year-old boy with frequent temper tantrums, rocking, social isolation, peculiar verbal behavior, stereotyped motor responses, obsessive drawing of television channel symbols, and physical attacks on parents, teachers, and peers. The second was a 5-year-old boy described as disobedient, defiant, hyperactive, destructive, and physically assaultive to his younger brother. First the parent-child interaction was analyzed. Home observations and clinic videotaping were carried out, and the mothers recorded home interactions with the children. In the clinic, mothers were observed as they interacted with their children, and were cued by a tone signal system. The mothers practiced specific instructions, involving the use of differential reinforcement and presenting a graded series of "maternal anger" cues. Videotapes of the interactions were later observed and discussed by therapist and parents. The first case reported cessation of "brat" behavior after 15 weeks of training, and a 2-year followup showed the improvements were maintained. In the second case, improvement was noted by multiple posttreatment observers in the home, and by parent and teacher reports.

Two aspects of the shift to greater methodological sophistication and parental responsibility are: shifting the focus from discrete behavior of the child to the parent-child *interaction system* as the target for intervention; and concern not only for behavior change, but also with *maintenance* of the new, desirable behavior. In essence, there is a shift toward training mothers in developing and maintaining more generalized competence in their interactions with their children, and this differs in concept and application from focusing on altering some discrete single-problem behavior of the child.

Large Scale Parent Training Programs

Whereas most parent training programs are small scale, involving from one to five children, some work has been done with larger numbers of parents. One 15-week parent training program was aimed at building operant-oriented family therapy focusing on the complex interactions among family members. Parents were taught skills in the analysis of behavior and application of operant principles to parent-child relationship problems. Problem behaviors ranged from school conduct problems to those of children labeled "autistic" or "psychotic." The program included: a "contract" with each family specifying details of their

participation; weekly group meetings of several families aimed at teaching behavior theory and technology through reading assignments, written homework, films, lectures, group discussions, modeling, and role-playing; weekly individual family sessions (with their therapist-consultant) held for specific applications to their own children; and before and after testing of parents, using videotapes, standard personality tests, and parental reports of behavior observations. The parents had the major responsibility for applying more home programs and identifying, observing, and recording problem behaviors. They were also taught to continue the application of principles to new behavior problems, independently, as they arose.

On the whole, this program was clearly a parent-training endeavor in which parents learned general behavioral concepts as well as specific techniques applied to their own children. The direction of the program was toward improvement of parents' general competence by means of observing and recording behavior, planning and carrying out sequenced programs, and increasingly doing so independently of the therapists. The program complexity, methodological sophistication, and parental involvement and responsibility were at high levels. The major weakness of the work was the lack of reporting specific data. Because of the program complexity and the lack of data, the program cannot be replicated but can, and undoubtedly will, be increasingly imitated.

Another study of 11 families focused on boys, ages 6 to 13. The boys were referred for high rates of negativistic and aggressive behavior—yelling, teasing, hitting, temper tantrums, and general noncompliance; children with severe brain damage and psychoses were ruled out. The families described were generally difficult to work with—the children, usually labeled "conduct disorders," represented difficult cases, and there was a disproportionately large number of low socioeconomic class families with fathers absent in four of the eleven homes. Although primarily focused on aggressive boys, the program analyzed sibling as well as parental behavior, and actually dealt with children and adults of both sexes and a wide range of behavior. For each family, baselines and posttreatment observations were made in the home by one or two trained observers, 1 hour daily for 10 days. Rigorous reliability checks were applied to rule out observer bias. The 10 to 12-week parent training program followed a sequenced, linear program model which required parents to master each portion in sequence. An early phase of the program was mastery of a programed text; next the staff trained and supervised the parents in observing, recording, targeting, and tracking behavior, as well as completing exercises such as devising programs for specific target behavior. The parents then joined a parents' group, in which they were supervised in applying a series of programs to alter their children's behavior. These groups involved role-playing, modeling, and discussions on the use of social reinforcement, including TO and token systems. Each day, as they carried out their home programs, the parents were telephoned and given close supervision of small daily details, immediate correction of errors, and reinforcement for their efforts. If the target behavior persisted, the parents were removed from the group and tailormade procedures were developed and applied on an individual-family basis. For all families, followups of at least 6 months were carried out to insure that changes were maintained. The main

findings showed significant decreases in specific deviant behavior of the targeted children. Most of the changes were found to have occurred in the first 4 weeks, and the total professional time involved was only about 12 hours per family. Generalization effects of the program were also investigated, and the data showed statistically significant: generalization across nontarget response classes of the client-children; improvement in the behavior of siblings of the focal children; and improvements in the parents' global descriptions of their children.

This program is a highly sophisticated and complex one in which parents are taught general behavior principles and their specific application to their own children. The approach aims to modify multiple classes of deviant child behavior by focusing on the family interaction system, and data on generalization effects support the idea that significant changes in one aspect of the family system can, and often does, lead to significant improvement in other aspects of the total system.

Suggestions for Future Research

The focus on parents-as-therapists opens a large area of research and development in clinical treatment methodology, ranging from basic and theoretical questions to highly practical, applied problems. The professional must provide more in the way of well validated methods of behavior change, as well as develop more successful and efficient approaches to training parents. Areas in need of investigation include: the development of possible predictive measures of the extent of parental success; further development and validation of a "family systems" framework of therapeutic intervention; the development of more precise measures of parental and child behavior change on attitudinal and interactional variables; and investigation of its preventive value, i.e., do disturbed children whose parents were trained in behavior modification have significantly fewer problems in the future than children whose parents were not so trained?

In light of the available evidence, there is little doubt that behavioral techniques can be effectively applied to children's problem behaviors through the training of their parents. The direct and practical coping with the everyday realities of the disorganized family's situation may be an important therapeutic need currently not met by most child therapists. This entire development provides a new framework for clinical intervention, which, in addition to therapeutic value, has important implications for future use in a systematic and prevention-oriented model of mental health intervention.

Note: This review has an 81-item bibliography.

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Sex Differences in Newborns with Special Reference to Differences in the Organization of Oral Behavior

Anneliese F. Korner

Behavioral sex differences have been noted in very young infants. Evidence is also mounting that from a very early age parents treat boys differently from girls. The question arises whether the sex differences noted in the earliest months of life are entirely a function of differential treatment. To resolve this issue, the obvious time to study sex differences is right after birth when differential treatment will not have had much impact.

Few neonatal studies have revealed sex differences, partly because investigators have not analyzed their data for such differences. Those studies which did assess sex differences have often shown inconclusive results. Where differences have been found, they have mostly been differences in responsiveness, particularly to external stimuli. Few differences have been found in the primary expressive behaviors such as those involved in spontaneous activation.

Individual and Sex Differences in Hand-to-Mouth Approach Behavior

In an earlier study on individual differences at birth, we observed that, in the approach behavior of hand-to-mouth, in some infants this approach behavior was mouth-dominated while others primarily sought such contact by coordinating the hand to the mouth. We wondered whether there were not from the start predisposing qualitative and quantitative differences in hand-mouth coordination. Because we had 1000 feet of film on 32 normal newborns in 16 timed-samples identical in length and in the interval since the last feeding for each infant, we were able to assess the relation of hunger, individuality, and gender to these differences in hand-to-mouth approach behavior. The infants were full-term Caucasian neonates ranging in age between 45 and 88 hours. Seventeen were male, 15 were female.

For analysis, film was run at 24 frames per second until a hand-mouth contact was observed. Instances of hand-mouth contact during yawning, crying, or as the result of startles were excluded. Otherwise, whenever a hand-mouth contact was seen, the film was stopped and reversed to the point where the beginning of the hand-to-mouth coordination could be identified. The approach behavior was then analyzed at the speed of four frames per second.

Four types of behavior sequences were observed:

The hand approached the mouth. This category was scored when, with the hand approaching the face, the mouth opened only when contact was established.

The mouth approached the hand. For this category to be scored the mouth had to open when the hand was at a distance of at least 1½ inches or more from the face; also, the infant's head strained forward in an effort to meet the hand.

The mouth opened when the hand was very close. This was scored when the mouth opened with the hand being at a distance less than 1½ inches.

The mouth strained after the hand to maintain contact which had been established.

The most common behaviors were

in the first two categories; because the third and fourth categories combined comprised only 10 percent of all responses, and both contained both hand approach and mouth-seeking, half of each was assigned to the first two categories for purposes of the data analysis.

The results showed that the most common approach behavior for all infants was hand-dominated (the group average was 66.7 percent). An analysis of variance was used to assess simultaneously the effect of sex, of the time since the last feeding, and of the individuality of the infants within the same sex on the proportion of mouth-dominated approaches. The sex of the child had the most marked influence on the infant's approach behavior, with girls engaging in significantly more frequent mouth-dominated approaches than boys.

Within the same sex, the children differed significantly from each other in how much they engaged in mouth-dominated approach behavior, which, at the same time, reflected the marked stability of this behavior within the children. Some individuals were so consistent in their style that one could accurately predict the proportion of each of their approach behaviors from one observation period to the next.

Time elapsed since the last feeding also increases the proportion of mouth-dominated approaches.

The proportion of hand-dominated or mouth-dominated approaches appears to be unrelated to the frequency, efficiency, or persistence of the infant's hand-to-mouth coordinations.

Innate Sex Differences

The cumulative evidence from several studies points to innate sex differences in special areas. The female emerges as more receptive to certain types of stimuli and as orally more sensitized, but not less active or expressive. Specifically, the female is more responsive than the male to cutaneous stimuli, electrotactual and photic stimulation, and the taste of sweetness. In the sphere of oral behavior, we noted the same dichotomy between those oral behaviors which are activity-related and those behaviors suggestive of sensitization of the mouth. We found no sex differences in the frequency or skill of hand-to-mouth coordinations or of fingersucking, but we and others found more rhythmical mouthing, more reflex smiling, more frequent quivering oscillations of the tongue during feeding, and more mouth-dominated, hand-mouth approach behavior in females than in males.

This evidence of innate sex differences does not, of course, detract from the fact that mothers treat infants differently depending on their sex and that there is constant parental reinforcement of what the culture considers to be sex-appropriate behavior.

What could explain behavioral sex differences at birth? The most frequent explanation of sex differences in older children is that girls mature earlier than boys. Statistics on perinatal morbidity support the notion that females are less vulnerable and, by inference, perhaps more mature. However, there is little reason to consider the particular behaviors in which female newborns exceed males as reflecting greater maturity.

Also mitigating against the idea that the sex differences at birth are best explained on the basis of maturational differences is the fact that for all of the characteristics in which sex differences have been found in neonates, there is evidence of continuity into later development of these same differences, either in direct or derivative

form. Specifically, the greater cutaneous sensitivity of the female neonate finds its counterpart in the adult female. Studies using evoked potential in response to electrocutaneous stimulation have shown shorter latencies and higher amplitudes of response in the adult female than in the male. Similarly, adult females showed shorter latencies and greater amplitudes of response to photic stimulation than males. The male newborn's greater strength as suggested by his greater capacity to lift his head and his greater tendency to engage in vigorous startles may foreshadow his later development which is characterized by superior physical strength. The finding that female newborns are more responsive to sweet taste is confirmed in the greater taste sensitivity and taste discrimination of adult females.

The evidence regarding the persistence of the female's greater mouth sensitization is more derivative: Female children are more frequent and more persistent thumbsuckers than male children. While on the whole the incidence of psychiatric developmental disturbances in the male exceed those of the female (i.e., learning disorders, speech pathology, autism, etc.), eating disorders and other difficulties connected with the mouth are more common in females. The ratio of the incidence of anorexia nervosa is from 10:1 to 20:1 in favor of females, and a higher prevalence of obesity has been reported for women. Furthermore, once women take up smoking, they are less likely to give it up than men.

What could account for the sex differences seen at birth which seem to persist through much of later development? Aside from possible genetic determinants, the most plausible explanation seems to come from the field of fetal endocrinology. The hormones responsible for sexual differentiation in utero may sensitize the organism's central nervous system in such a way that sex-linked behaviors will emerge even at a later time when the circulation of these hormones is no longer detectable. The principal hormones involved in sexual differentiation appear to be androgens. To become male, the undifferentiated fetus must first develop testes; then the fetal testes must secrete male hormones (androgens) for the embryo to become male. To explain the neonatal behavioral sex differences pointing to greater sensitization of the perioral region and of the skin in the female, I postulate that the prenatal circulating androgens produced by the male may suppress the male's perioral responsiveness and skin sensitivity. Animal research indicates that ovarian secretions may stimulate the taste preferences of females and that testicular secretions may suppress the comsumption of sweets by males. Possibly both types of hormonal actions may contribute to the sex differences noted in human neonates. The female fetus may be more heavily exposed to the freely circulating maternal estrogens by virtue of not producing androgens that counteract the influence of the estrogens. Also, the presence of testicular secretions by the male may have a direct suppressive effect. It may thus be the counteracting and/or suppressive action of the androgens which may account for the male's lesser interest in the taste of sweetness, and possibly also for his diminished sensory responsiveness of both mouth and skin.

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Alcoholism and Drunken Driving: Evidence from Psychiatric and Driver Registers

Nathan Rosenberg, Irving D. Goldberg, and George W. Williams

The establishment in 1961 of the Maryland Psychiatric Case Register and the National Driver Register has provided a basis for exploration of the relationship between drunken driving and alcoholism. Because, in the Maryland Register, psychiatrically diagnosed alcoholic patients are identified by name, and because the National Driver Register provides information by name concerning revocation of driver licenses for drunken driving, matching of the two has permitted us to study the question of whether these alcoholics were disproportionately represented on the National Driver Register.

The Maryland Psychiatric Case Register—The Maryland Psychiatric Case Register (MPCR) was established on 1 July 1961. All facilities in Maryland that provide psychiatric services are asked to report on all psychiatric patients served. As of July 1965, the last year for including psychiatric cases in this study, more than 130 facilities had contributed information to the Register. It is estimated that these facilities handled more than 97 percent of all Maryland psychiatric admissions. Because psychiatrists in private practice do not report to the MPCR, some outpatients from upper socioeconomic groups may not have been in the Register.

A one-page report form on each psychiatric patient includes name and other identifying information, social and demographic data, and diagnostic and other psychiatric information relating to the patient's episode of care. Similar data were obtained on an initial reporting of patients under care on 30 June 1961, the day preceding the formal initiation of the Register.

The National Driver Register—The National Driver Register (NDR), maintained by the National Highway Traffic Safety Administration in the U.S. Department of Transportation, became operational in July 1961. It was originally authorized to file only reports of drunken driving and suspensions and revocations of driver licenses as a result of fatal accidents. This was subsequently amended to permit filing of virtually any State-recorded denial, suspension, or revocation of driver licenses. These voluntary reports are the primary source of information in the Register. Data recorded include name, sex, date and place of birth, other identifying information, date and reason for license denial, withdrawal, or revocation.

Matching the Registers—The matching process was performed in July 1968 using the current NDR computer file, which then contained over 1,000,000 names of persons whose licenses had been revoked for drunken driving. The MPCR file used contained information about 75,187 persons first reported to that Register during the period 1 July 1961 to 30 June 1965 or already under care on the first of these dates.

The MPCR was matched against the NDR; variables used in the matching process included name, date and place of birth, and sex. On the basis of the computer match and clerical review of all potential matches, persons on the MPCR were classified as probable match, possible match, or definite nonmatch against the NDR. Because of sample size considerations and the focus on alcoholism, the data analysis was confined to white male residents of Maryland who appeared

on the NDR for license revocation caused by drunken driving rather than for some other offense. Thus, the final group consisted of 29,039 white men on the MPCR who were at least 13 years of age on 1 July 1968, whose first reported admissions to psychiatric facilities were before 1 July 1965, and who, prior to the latter date, were Maryland residents.

Classification of psychiatric diagnosis—"Alcoholism," as used in this paper, represents the psychiatric diagnosis defined as acute or chronic brain syndrome associated with alcohol intoxication, or alcoholism (addiction). Each individual was assigned a single diagnosis, even if he had received different ones at different times; if on any separation report the diagnosis was alcoholism, the first such separation diagnosis was used for classification by type (alcohol addiction or brain syndrome associated with alcoholism). If alcoholism was never the separation diagnosis or if the patient had not left, the first alcoholism diagnosis at admission was used. For patients never diagnosed as alcoholics, the most recent separation diagnosis (or admission diagnosis if the patient had not left) was used.

Results of Matching Registers

Psychiatric diagnosis—The patients whose MPCR records were analyzed were distributed by psychiatric diagnosis and degree of match against the NDR. Of this group, 838 (2.9 percent) were probable matches with persons appearing on the NDR, 205 (0.7 percent) were possible matches, and 27,996 (96.4 percent) were definite nonmatches. Of the 5157 alcoholic patients, 564 (10.9 percent) were found to be probable matches, compared with only 274 (1.1 percent) of the 23,882 nonalcoholics. Thus, the probable match rate of the alcoholics was about 10 times that of the nonalcoholics. These data demonstrate the overrepresentation of alcoholic, as opposed to nonalcoholic, psychiatric patients on the NDR.

Matches classified as possible discriminate poorly between alcoholic and nonalcoholic patients. Possible matches, therefore, were added to definite nonmatches, and this combined group (hereafter referred to as nonmatches) was compared with the probable matches.

The alcoholism-addiction group produced a higher probable match rate (12.8 percent) than the brain-syndrome group (7.1 percent). Except for these and the sociopathic group, no diagnostic group studied exceeded a match rate of 2 percent, although the probable match rates of other patients with personality disorders (2.0 percent) and psychoneurotic patients (1.7 percent) were somewhat higher than the rest. Diagnostic groups with relatively low probable match rates included mental deficiency (0.3 percent), transient situational personality disorders (0.5 percent), brain syndrome without alcohol intoxication (0.6 percent), and the undiagnosed or those without mental disorders (0.9 percent). It should also be noted that the alcoholism diagnostic category represented 17.8 percent of the total study group and was the largest single diagnostic grouping on the MPCR.

Type of care, alcoholism diagnosis, and residence—Probable matches were further examined with respect to type of psychiatric care, type of alcoholism diagnosis, and residence. Patients were classified as inpatients, outpatients, or both. Although utilization of inpatient rather than outpatient facilities might in part have reflected geograhic variations in availability of beds or services, the inpatient-outpatient distinction was conceptualized in

this study as a reflection of the severity of a psychiatric condition—for alcoholics, the severity of their involvement with alcohol. Patients were also classified as residents or nonresidents of Baltimore since Baltimore is the only large urban area in the State, and large urban areas have been found to produce higher alcoholism rates.

The overall probable match rate (10.9 percent) of the total alcoholism sample is the weighted average of the 12.8 percent rate of the 3500 persons in this sample diagnosed as addicted to alcohol and the 7.1 percent rate of the 1657 patients diagnosed as brain-syndrome alcoholics. The higher match rate in the addicted group in the total sample was also found in each of the three types of care and within the two residence groups studied. In the addicted group, the match rate ranged from 8.3 percent in the 169 residents of Baltimore who received only outpatient care to 16.8 percent in the 529 nonresidents of Baltimore who received both inpatient and outpatient care.

Chi-square analysis of the match and nonmatch frequencies among alcoholics showed that the difference in match rate by residence and by alcoholism type were both significant. Diagnoses of brain-syndrome alcoholism and Baltimore residence produced the lowest match rate and diagnoses of alcohol addiction and nonresidence in Baltimore the highest. Fewer than 10 percent of the alcoholics in the MPCR group received only outpatient care (12 percent of the addicted and 3 percent of the brain-syndrome group), and therefore such patients represent a relatively small proportion of all alcoholics in the MPCR.

Although match rates of residents and nonresidents of Baltimore differed, the proportion of those who matched who were alcoholics was essentially the same—about two-thirds. Similarly, in either residence group, three-fourths of the matches who had had any inpatient care and about 30 percent of those with outpatient care only had received a diagnosis of alcoholism.

Among the nonalcoholics, the match rates, although appreciably lower, generally follow the same pattern as for alcoholic patients—higher in nonresidents of Baltimore and in those having received inpatient care. The match rates of the total nonalcoholic group ranged from a low of 0.9 percent in several subgroups to a high of 1.8 percent in nonresidents of Baltimore having received both inpatient and outpatient care. Nonresidents of Baltimore who had received both inpatient and outpatient care produced the highest match rate among the nonalcoholic as well as among the alcoholic patients.

Age—The mean ages used were those at the patients' first MPCR-reported admission. Among the alcoholics, the brain-syndrome group was generally older than the addiction group: The mean age of the 3500 addicted alcoholics was 43.9, of the 1657 brain-syndrome-type alcoholics, 48.0. Among those who received outpatient care only, however, the addicted alcoholics had a slightly higher mean age at first admission than the brain-syndrome alcoholics.

Among the alcoholics, the probable matches were younger than the nonmatches. Thus, the mean age of all 564 probable matches with an alcoholism diagnosis was 42.3 years; of the 117 brain-syndrome type, 42.7; of the 447 addicted type, 42.2. In contrast, mean ages of alcoholics who were not matches were 45.6, 48.4, and 44.2, respectively.

In view of the relationship of age to psychiatric diagnosis as well as to po-

tential driving exposure, the match rate by diagnosis was also determined with respect to age at which the patients comprising the MPCR population were first admitted.

Among persons whose first admission occurred at age 15 or later, the match rate was about 7.5 times as great in patients with alcoholism diagnoses (10.9 percent) as in those with nonalcoholism diagnoses (1.5 percent). Despite differences in the age distributions of the alcoholics and the nonalcoholics, this alcoholic-nonalcoholic ratio in match rate was unrelated to age at admission.

Implications

White men alcoholic patients appear to have a risk of conviction for drunken driving about 10 times that of nonalcoholic psychiatric patients. The fact that this overrepresentation was found to be so great suggests that the NDR provides a resource for identifying known or potential alcoholics.

Data from this study can also be used to estimate the percentage of drunken drivers diagnosed as alcoholics. According to data supplied by the Maryland Department of Motor Vehicles, there was an annual average of 2441 license revocations per year because of drunken driving during the period July 1965 to June 1968. Since the 564 probable matches in this study appeared after 4 years' experience with the MPCR, it may be estimated that there were 141 white men alcoholics per year with a drunken-driving conviction—almost 6 percent of all Maryland license revocations because of drunken driving. Data are not available concerning the proportion of all drunken-driving license revocations occurring among white men, but 80 percent would seem reasonable. On this basis, about 2000 of the 2441 revocations would occur among this color-sex group, so that the 141 revocations among alcoholism cases would represent about 7 percent of the total for white men. Thus, it is estimated that about 7 percent of the white male Maryland residents convicted of drunken driving at some time receive a psychiatric diagnosis of alcoholism in an inpatient or outpatient facility reporting to the MPCR.

The high match rate against the NDR, especially among alcoholics, appears important when it is realized that the MPCR included an unknown number of persons who were not licensed drivers as well as some who had little opportunity to drive because they were inpatients for extended periods.

Reduced exposure to driving may similarly account for the finding that alcoholic patients diagnosed as the brain-syndrome type have a lower match rate than those diagnosed as the addiction type. It is also possible that exposure to driving is greater in rural Maryland, where travel by car may be more essential than in an urban area such as Baltimore, and that this may account in part for the greater match rate found in nonresidents of Baltimore.

Since convicted drunken drivers constitute a group with a high rate of alcoholism, it is evident that such convictions represent a significant means of casefinding. It is also apparent that the NDR has potential for several research studies in the alcoholism area, including one in which an estimate of the prevalence of alcoholism in the United States might be obtained.

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All Things to All People

Henry Weihofen

A community mental health center can hardly expect to treat the mental problems of its patients without becoming involved in their nonmental and nonmedical problems. Some of these problems are legal, yet few centers have a lawyer on the staff. Problems encountered may be divided into those that concern the center administration or staff, those that are enmeshed in the emotional problems of individual patients, and those of concern to the whole community or its agencies.

Lawyers and Mental Health Center Administration

Legal services for administration and staff would consist of consultation and advice on legal questions that directly concern the powers, duties, and liabilities of the center and individual staff members. The danger of potential center or staff liability for negligent injury is ever-present. The center should obtain insurance coverage for such risks and should consult an attorney to make sure that all possible bases for liability have been covered.

Every "comprehensive" center must solve the problems incident to providing continuity of care in moving a patient and his records from one service to another. Serious questions arise: Can one component be held legally responsible for the negligence or malpractice of another? Must the center supervise the operations of its affiliates to make sure they are exercising adequate standards of care? Who is responsible if the patient gets hurt as he moves through the network of services? The services of an attorney are essential for determining the degree of control over the affiliates that should be provided and its implications for legal liability.

In a center rendering a number of services, problems of maintaining confidentiality arise when records have to be transmitted from one service to another. An even more sensitive problem involves determining what persons or agencies outside the center shall be given access to patient records. This involves the law of libel and slander, the right to privacy, sovereign immunity, and the law governing privileged communications and public records. Access should not be given without legal consent, but certain cases—such as those which involve minors or mentally incompetent persons—raise many questions as to who is legally authorized to give consent.

Admission procedures is another area where the number and variety of serious questions call for readily available legal advice. Forms which should be drafted by legal counsel are: applications for voluntary admission, judicial commitment, and emergency commitment; a request for release against medical advice; or an application by parent or guardian for voluntary admission of a minor.

Even though the courts wish to have a psychiatric evaluation, some centers hesitate to accept persons who are under criminal charge, fearing that the center would be held responsible if such a person escaped or committed a criminal act while under its control. Administrators assume such persons

must be kept in close confinement, yet the center may not have and may not want locked wards. Legal counsel might work out understandings with the courts on the procedures to be followed.

Lawyers could educate staff members in forensic psychiatry, giving to psychiatric residents some understanding of legal issues involved in psychiatric evaluations, and teaching them how to prepare proper reports for court purposes and how to comport themselves as psychiatric expert witnesses.

In research it is necessary to bear in mind that patients have fundamental human rights such as protection against unwarranted invasions of privacy, the right to refuse consent to a surgical or other procedure, and the right not to be a research guinea pig. Here again legal advice is needed in drafting consent forms and in making sure that staff members obtain signatures to such forms whenever any unusual therapy is undertaken.

Other questions that arise where counsel may be of help include the steps taken when a voluntary patient demands release or elopes; whether a nurse or a social worker may sign out an inpatient for a home visit; whether a nurse may administer drug therapy; whether payments to patients in a work-therapy program violate the minimum wage law or will be deducted from welfare benefits; and whether certain types of cases must be reported to the law enforcement authorities.

Lawyers and Mental Patients

Mental health centers encounter multiproblem families, where mental illness is only one of many troubles, which hinder therapeutic efforts. The problems range over a large and miscellaneous area, but many fall into a few particular fields— family law, welfare law, juveniles, and financial crises.

In family law, a patient may be having difficulties with his or her spouse who may have filed divorce or separation proceedings. Legal counsel can get in touch with the other party's lawyer, assess the state of the proceedings, and advise the patient what his legal rights and liabilities are and what course to pursue.

Also, where the patient is a pregnant, unmarried girl, counsel may be of help to her and her family in advising whether to elicit financial help from the father or whether to give up the child for adoption.

In the second field, welfare, entitlement to assistance is as important for the poor as are more traditional legal rights. To guide the poor person through the welfare structure maze to gain his legal rights, the joint efforts of social worker and lawyer are needed. The lawyer also can become familiar with the basic protection principles that have been incorporated as conditions of Federal grants to the States. These include prompt and equitable treatment without discrimination, and program administration in such a way as to protect the dignity and self-respect of recipients.

As tenants, the poor often cannot get the services and repairs that health and housing codes require. Public housing authorities may have controls not applied to persons who live elsewhere. Thus, a family with a retarded child may be denied housing on the ground that it is "unsuitable."

A destitute family about to be put out on the street may desperately need someone who can file a show-cause order or other court action against the landlord to gain time for other quarters to be found.

In cases of patients whose mental

troubles are aggravated by troubles with their children and child patients who are victims of abuse or lack of services, a lawyer can help in criminal proceedings, in challenging a school board, in helping parents to get their child admitted to an institution or to services, or in facilitating psychiatric examination of juveniles brought before the court.

When parents will not or cannot properly care for their children, counsel may also be called on to represent the children in legal action to terminate the parental rights. The availability of a legal spokesman in these cases can also put pressure on the courts and other authorities to change custody policies.

For patients whose condition is aggravated by financial worries and harassments, a lawyer can help in getting the gas, electricity, or water turned back on, or in cutting through the procedural red tape to get welfare or social security benefits.

Equally important are legal questions that may arise concerning right to workmen's compensation or unemployment compensation for mental disability and the procedures for applying for such benefits.

Lawyers and the Community

The mental health center is committed to render services to several agencies in the community; one of these would be the courts. The mental health center legal personnel could pay a role in promoting innovative alternatives to funneling all domestic disputes into the courts. A lawyer on the staff can facilitate arrangements for the courts to use the center for psychiatric evaluation and can train police in identifying and handling psychiatric emergencies, alcoholics, drug addicts, juveniles, sex offenders, and persons who have threatened or attempted suicide.

Still another important service to the community is that of informing the bar of the services a new center renders—both to the mentally ill and to their attorneys. Clinic experience shows that emotionally disturbed persons often present themselves initially to law offices with legal problems, which may be expressions of psychiatric difficulties. Lawyers need to recognize such cases and know how to refer them for psychiatric care. Courses for law students could be offered in law and psychiatry, and clinical material could be prepared for use in other courses. The center could operate a consulting service for individual attorneys representing clients who seem to be distrubed or for those appointed by the court to represent indigents.

In providing consultation services to schools, public health officials, and clergymen, legal questions arise. Can the center give a pregnant high school girl help without the parents' consent? Or may a welfare client legally be provided with a birth control device?

A lawyer on the staff of the mental health center is a logical person to consider whether the State's mental health laws are up-to-date and adequate. Most of our State hospitalization laws were enacted at a time when the only facility for commitment was a State hospital, and local statutes may require amendment before a court can send a person to a community mental health center or order less intensive treatment. Amendment may also be needed to facilitate transfers of patients between such centers and the hospital.

The last area where having a lawyer on the community mental health team proves uesful is that of social action. Providing help for individual troubles

accomplishes nothing lasting if the conditions that produced these troubles aren't corrected. This calls for radical changes in our economic and social structure, and the staff lawyer is in an excellent position to work for a cooperative effort with other professional experts and government officials to formulate social reforms.

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Donaldson v. *O'Conner*—Florida Case Underscores Right to Treatment

In November 1972 a Federal district court jury in Tallahassee, Fla., ruled that psychiatrists in a State mental facility are liable for damages if they neglect to provide treatment for a patient committed to their care. The first of its kind in the United States, the *Donaldson v. O'Conner* case underscores the "right to treatment" concept heralded by the Alabama landmark case of *Wyatt v. Stickney*.

Several concepts were emphasized in the court's instructions to the jury: The burden was on the plaintiff to establish that the defendant doctors confined the plaintiff against his will, knowing that he was not dangerous, and knowing that if he was mentally ill he was not receiving treatment for his illness. A person who is involuntarily civilly committed to a mental hospital has a constitutional right to receive appropriate treatment. The plaintiff did not have to prove that the defendants acted in bad faith or maliciously, just that the plaintiff was not dangerous and received only custodial care.

Having been involuntarily committed to the State mental hospital in Chattahoochee in January 1957 with a diagnosis of schizoid paranoia, plaintiff Kenneth Donaldson was not released until July 1971. He then brought suit against the hospital Superintendent Dr. J. B. O'Conner and Staff Psychiatrist Dr. John Gumanis. Both physicians were sued as individuals, and the State Department of Health and Rehabilitative Services, which runs the hospital, was not implicated in the case. During the patient's 15-year stay in the institution, he had never received treatment for his mental condition, and he was not afforded proper periodic reassessments of his psychiatric condition. Entered as evidence in the trial, hospital records revealed that in some instances years passed without progress reports on Donaldson's condition.

After deliberating for 2 hours and 15 minutes, the jury ruled that both physicians were guilty of neglect and liable for both compensatory and punitive damages. The assessment was put at $22,000 against Dr. O'Conner and $16,500 against Dr. Gumanis; thus a total of $38,500 was awarded to Mr. Donaldson.

1974 Federal Budget for Mental Health

The Federal budget for mental health programs are shown in the following figures and accompanying explanatory paragraphs as contained in a press release issued by the Office of the Secretary, DHEW. (Dollar figures in millions)

	1972 actual	1973 estimate	1974 estimate	Change
General Mental Health:				
Research and Training	$201	$161	$152	— 9
Community Mental Health Centers	160	134	518*	+384
Drug Abuse:				
Research and Training	36	42	51	+ 9
Community Programs	81	149	382*	+233
Alcoholism:				
Research and Training	13	10	11	+ 1
Community Programs	69	60	117*	+ 57
Saint Elizabeths Hospital	30	36	38	+ 2
Administration and Information	43	48	51	+ 3
Total	$633	$640	$1,320*	+680

* Includes costs beyond 1974 to support previously approved CMHC grants: $384 million for general mental health; $205 million for drug abuse; and $47 million for alcoholism.

Community Mental Health Centers—Over the past 9 years, NIMH has stimulated the establishment of 515 community mental health centers across the country. This was the principal thrust of a movement to treat persons with emotional illness near their homes, often on an outpatient basis, including care after a period of hospitalization, accompanied by consultation and education programs to avert breakdown. The aim was to move away from costly and ineffective long-term and custodial care in State mental institutions. The workability of the community mental health center concept has been thoroughly demonstrated and a large portion of a national system will have been put into place when the 8-year grants provided for in current law are concluded. The Administration proposes that the Community Mental Health Centers Act be allowed to expire on June 30, 1973 on the grounds that the current momentum behind the community mental health concept should be adequate to maintain existing centers and stimulate the establishment of new centers.

The termination of Federal support for community mental health centers applies to both general staffing grants and also special impact programs such as child mental health, alcoholism, and drug abuse. However, the 1974 budget includes the budget authority needed between now and 1980 to honor *all* Federal staffing grant commitments to existing community mental health centers for continuation support. Thereafter, reliance for financing is expected to be placed on payments and contributions by individuals, State and local governments, and on reimbursements from third party payment systems.

Alcoholism—Formula grants for the States for alcoholism programs will continue at the level of $30 million in both 1973 and 1974. However, no new project grants will be awarded and when existing continuation commitments run out, the project grant program is slated to be discontinued. The project grant program, since it was established in 1971, has funded 492 projects in communities across the nation. The effect of these projects has been to increase national awareness of the problem of alcoholism and build State and local capacity to handle the problem. The ultimate solution, however, must depend on locally initiated and supported efforts. The project grant program has helped to point the way, but future Federal support should be channeled exclusively through formula grants.

Drug Abuse—Although the special community mental health center staffing grants for drug abuse will be phased out, the project grant effort being carried out under the general leadership of the Special Action Office on Drug Abuse Prevention will be expanded. Through 1973, 276 drug abuse projects will be underway. Evidence shows that 50 to 60 percent of drug addicts will volunteer for treatment if service is available and of acceptable quality. The projects provide detoxification, methadone maintenance, rehabilitation, and aftercare services. The State formula grant for drug abuse initiated in 1973 will also be continued at the $15 million level in 1974.

Training Grants and Fellowships—The 1974 budget provides only continuation grants for students currently receiving NIMH assistance. As current commitments have been fulfilled, support for the more traditional forms of long-term categorical training in selected professional disciplines is proposed to be terminated. This is part of a general policy to eliminate most subsidies for specialized training in selected professional disciplines. It is anticipated that the general student assistance programs of the Office of Education will provide all of the Federal assistance needed to assure an adequate supply of manpower in these disciplines. Future emphasis will be on experimental development and evaluation of new training models with short-term Federal commitments and greater applicability to service delivery needs at the regional, State, and local level. State and local funds would be employed to develop and maintain successful programs following the initial period of pilot Federal support.

St. Elizabeths Hospital—The 1974 budget carries out the previously announced plan to transfer this facility to the District of Columbia. About 85 percent of the patients treated at the hospital are D. C. residents. The budget includes funds to pay full costs for Federal beneficiaries receiving care at the hospital and, in addition, provides the first installment of a subsidy to the hospital. Arrangements are being developed with the D. C. Government for an increasing role in the hospital's administration prior to official transfer. Provisions will also be made for improving the physical plant. Because current operating costs are higher than the present level of reimbursements by the District of Columbia, an annual subsidy will be provided over a period of years to permit a gradual assumption of full funding for D. C. residents by the District of Columbia.

Attorney General in New York Studying Abuses in the Field of Mental Health

The following item is condensed from a statement made by Dr. Robert J. Campbell in behalf of the New York State District Branches of the American Psychiatric Association at a hearing on abuses in the mental health field held by Attorney General Louis J. Lefkowitz on December 15, 1972:

The fundamental commitment of psychiatry, like all medical specialties, is to the health of people. We wholeheartedly endorse the investigation of the New York State Attorney General into abuses in the mental health field.

Not all consumers can be expected to develop the competence to evaluate the applicability and efficacy of different therapies. It is therefore essential that the public be protected against the consequences of inadequate or inappropriate treatment. In mental health, such protection is a continuously pressing need, since persons who suffer from mental illness or emotional disorder are ordinarily unable to identify which of the broad range of available services are services that are most appropriate to the condition that afflicts them. Licensure of professionals is one protective measure, and a necessary one. But by itself it is not sufficient to ensure protection of the consumer.

Abuses in three categories—Abuses within the mental health field can be divided into three categories. First, the abuser has had no training or expertness within the mental health field. He escapes control by disguising his practice as a form of religion, as a self-help group, as palmistry, etc. "Omnibus" licensing of such groups would spawn a plethora of "mini-professions," at a substandard level from the point of view of consumer protection.

Second, the abuser falsifies his credentials. He passes himself off as qualified in areas where he has had no or inadequate training. Once the fraud is uncovered, this abuser may be prosecuted for practicing without a license. The abuser whose training is inadequate, but in a related field, represents a vexing problem unless the licensure law spells out the areas in which competence must be demonstrated. The pending psychology licensing bill does exactly that for psychology.

Third, the abuser has been adequately trained and supervised. He is legitimately licensed, but his professional practices fall below or outside the standards for the profession. There are two subtypes, but the licensure laws do not differentiate between them. One subtype can be termed misconduct, as when a practitioner misuses his profession as a cover for or inducement to illegal or improper behavior. The other subtype is an error of omission; it consists of a failure to maintain the highest standards of professional care. Sometimes the standards deteriorate because of the professional's failure to keep abreast of significant developments. More commonly, the impairment reflects illness within the practitioner himself, and particularly neuropsychiatric disorder, alcoholism, or drug abuse. The licensure law was designed to correct, obliterate, and abolish such threats to the public safety, but for all practical purposes the law is unworkable.

The law requires revision, and the Medical Society of the State of New York last year recommended the establishment of a Task Force to study this subject. What is further required is an ongoing evaluation and regulation of professional

practices within the professions themselves. The current emphasis in medical specialties on peer review and continuing education are examples of what every mental health discipline must do to ensure that each citizen who needs it will receive appropriate, responsible, and comprehensive care of the highest quality. (From *The Bulletin* of the New York State District Branches, American Psychiatric Association, January 1973)

Michigan Psychiatric Society's Task Force on Confidentiality

In 1971, the president of the Michigan Psychiatric Society appointed a Task Force to review the problem of confidentiality of patient records. The problem was the Auditor General's access to the psychiatric and social work portion of the medical records of all patients hospitalized at State hospitals in Michigan.

The Task Force decided that the problem was a major and important one and that something should be done about the problem. They proposed three solutions: (1) The Auditor General's staff would obtain release authorizations to review the psychiatric-social work portion of each record. (2) The hospitals would maintain the confidential portion of the record separate from the remainder of the record and only release it with proper (patient or guardian) authorization. (3) A team of independent psychiatrists would audit the psychiatric portion of the records after obtaining releases.

No action has been taken on any of these points. The possibility has been considered that the Society engage in a class-action suit on behalf of the patients to resolve the legal question.

A second issue centered around confidentiality and patient rights regarding release of information to insurance carriers. A patient signing a release of information may not be giving his informed consent if he is not aware of the content of the medical summary. A related issue was life insurance for someone with psychiatric history. In a survey of eight insurance companies, six indicated that there are restrictions and two had inadequate answers.

Another issue has arisen in relationship to information supplied to the Department of Mental Health for a data bank in Lansing. The purpose of gathering such information was to determine the efficiency and effectiveness of mental health programs as they exist throughout the State in agencies funded by the Department of Mental Health. After meetings, discussions, memorandums, and letters, the issue was hopefully resolved by the elimination of the use of patients' names, addresses, and social security numbers as required (and submitted) information being sent to Lansing. (From a report in the *Newsletter* of the Michigan Psychiatric Society, January–February 1973. Further information may be obtained from William E. Kirk, M.D., Chairman, Task Force on Confidentiality, York Woods Center Box A, Ypsilanti, Mich. 48197)

Telephone Calls Help Reduce Readmissions

In 1970 Central Louisiana State Hospital opened a 36-bed experimental unit for patients who had been admitted four or more times. One feature of the program, supported by a Hospital Improvement Project grant from NIMH, is a liberal telephone policy. Counselors, patients, and family members are encouraged to make long-distance calls for all relevant matters during the patient's hospitalization and aftercare.

The policy was instituted to see whether the readmission cycle could be broken by keeping the family involved during the patient's hospital stay and by dealing immediately with crises during aftercare. The plan has been effective for both phases of treatment.

Case counselors use the telephone to obtain information from the family that was not available at the time of admission, to make aftercare plans with the family and community agencies, and to make followup inquiries. Families and community agencies call collect to ask about visiting and other hospital policies, check on the patient's progress, report on his behavior on home visits, and communicate family news. With the approval of the case counselor, a patient may call home to inquire about family emergencies or other matters.

After the patient goes home, he or his family call to obtain advice on practical problems, report developments in posthospital adjustment, and request help in crises. Crises calls are referred to local agencies if they cannot be handled by phone.

The families like the immediate help and the feeling of staff's personal interest, as well as the reassurance of being able to speak directly with the patient. The voice-to-voice contact between the unit staff members and the community agencies also results in a friendlier, more helpful exchange of information.

The case counselors feel that the telephone has major advantages over correspondence: better, more immediate cooperation from families and agencies; ability to contact more informants and to make instantaneous decisions based on current relevant information; and capacity to prevent minor difficulties from becoming crises that require readmission.

Those impressions are supported by a study after 17 months of operation. Impact on rehospitalization is shown by a readmission rate for the unit of only 11 percent, compared with 36 percent for a multiple-readmission group treated elsewhere in the hospital. Although the unit had other advantages, including a modified token economy and more home visits, the use of the telephone, particularly during aftercare, seemed to be the most significant factor.

During the first year, in which 95 patients were treated, 728 long-distance calls were made. Only 62 were collect calls from patients or families; families often called at their own expense. In only one case was it necessary to request a reduction in calls.

Charges for long-distance calls average about $90 a month—far less than the cost of home visits and even of a comparable amount of mail correspondence. (From an item by Thomas E. Deiker, Ph.D. and Terry J. Villemarette, M.S.W. in *Hospital and Community Psychiatry,* 24(2):71, 1973)

Institutes of Religion and Health

The Institutes of Religion and Health has recently been formed by the merging of the Academy of Religion and Mental Health and the American Foundation of Religion and Psychiatry.

The Academy, with a membership of clergymen of many faiths, physicians (especially psychiatrists), psychologists, cultural anthropologists, sociologists, and social workers, holds interdisciplinary symposia, seminars, and annual meetings. It publishes books, monographs, a newsletter, and the quarterly *Journal of*

Religion and Health. Collaborating with national and international governmental and nongovernmental agencies, it continues to pursue its goal of improved mental health on a broad scale.

The Foundation emphasizes a commitment to training, innovative treatment programs, and application of religious values to the healing and helping processes. Through its Blanton-Peale Graduate Institute, with a staff of psychiatrists, psychologists, social workers, pastoral counselors and pastoral counsel residents, and marriage counselors and marriage counsel residents, and through its clinical affiliates and clinics and training centers in many parts of the country, it carries on an expanding program of professional training and clinical service.

For information about the Institutes of Religion and Health, write to the *Journal of Religion and Health,* 16 East 34th Street, New York, N.Y. 10016.

Student Paraprofessionals Augment Staff of a University Counseling Center

At the Colorado State University Counseling Center a new program employing students as paraprofessionals has met with praise from both the students and the Counseling Center staff. In addition to increasing the number and type of clients the Counseling Center serves, the presence of students on the staff has sharpened the professional staff members' awareness of student concerns and life styles, and the students offer valuable new ideas for programs and operations. The center finds itself more attuned to and able to respond to student needs, and the student paraprofessionals have helped to establish better communications between the Counseling Center and other campus offices.

The student paraprofessionals themselves enjoy the jobs as a learning experience and as an opening step into the university system where they have a chance to make some impact on the handling of problems that are important to students. Being responsible for operating programs, they are developing skills that will be useful on future jobs, and they feel that their skills are recognized and appreciated by the school.

The paraprofessional programs are of two general types—those for service to the general student population and those for service to individuals or small groups. Students apply for a paraprofessional job that has been described in terms of the specific tasks to be performed; after initial screening the final selection for each position is made by the Center's professional staff member who will be the supervisor for the job.

All training has pre- and in-service components. The job-specific training is monitored by the student's supervisor, and a coordinating group and the paraprofessional program coordinator provide core training in skills basic to helping jobs.

Programs run by the paraprofessionals cover a wide range—for example, minority and women's relations, renters' rights, communication skills, test desensitization, and discussion groups held in conjunction with academic lectures. The paraprofessional program evaluation is conducted on three levels: program implementation, general service, and individual performance. (From *Campus Community Mental Health Services,* Western Interstate Commission for Higher Education, January 1973)

recent nimh publications

Single copies of these publications may be obtained from the Public Inquiries Section, National Institute of Mental Health, Room 15C17, 5600 Fishers Lane, Rockville, Md. 20852. A complete list of all publications available from the NIMH may also be obtained from the Public Inquiries Section. If a price is given, the publication may be ordered in quantity from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Enclose a check or money order payable to the Superintendent of Documents.

Mental Health and Social Change: An Annotated Bibliography. Introductory guide to the major sources of mental health information relevant to social change. Emphasizes perspectives, conceptual tools, and methods used in studying behavioral processes associated with social change in America. DHEW Publication No. (HSM) 72–9149. $3.

Proceedings of the Joint Conference on Alcohol Abuse and Alcoholism. A 273-page book reporting on the interagency conference held in February 1972 to coordinate nationwide approaches to: alcohol-related offenders, public inebriates, and the drinking driver. DHEW Publication No. (HSM) 73–9051.

Experience Placements—Mental Health Career Development Program, 1973 Edition. A 121-page book listing challenging job opportunities for the mental health professional in Federal government programs. DHEW Publication No. (HSM) 73–9070.

Alcoholism Halfway Houses—General Characteristics. Statistical Note 73. Data on rehabilitation facilities for alcoholics. DHEW Publication No. (HSM 73–9005).

Federal Government Publications on Drug Abuse. NCDAI Report Series, No. 2.

The Documentation of Clinical Psychotropic Drug Trials. A workbook of those interested in clinical assessment and research of psychotropic drugs in psychiatric populations. An aid in understanding BLIPS computer-generated data output. DHEW Publication No. (HSM) 73–9038.

Crime and Delinquency Abstracts. Volume 8, No. 6. DHEW Publication No. (HSM) 73–9004. 65¢

Proceedings: Seminar on Alcoholism Emergency Care Services. Suggests comprehensive treatment and rehabilitation systems for emergency care of alcoholics utilizing various community resources. DHEW Publication No. (HSM) 73–9024.

A Nationwide Survey of Mental Health and Correctional Institutions for Adult Mentally Disordered Offenders. William C. Eckerman's collection and analysis of security hospitals and publicly operated facilities in the United States. Data includes physical and administrative features, treatment programs, and patient numbers. DHEW Publication No. (HSM) 73–9018.

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